MEDICAL HISTORY QUESTIONAIRE

Patient Intake Form Meaningful Use Measures

Our practice is now using an electronic health record. We are participating in the meaningful use incintive program sponsored by the federal government. We are collecting this data to be compliant with the program in an effort to increase patient safety, improve patient care and create a complete patient record. We appreciate your assistance with providing our practice this information about your health information.

* Please fill out completely and return to the receptionist. *

Required Information	Please fill in information in the area below
Full Name	
Date of Birth	
Gender	
Race	
Ethnicity	
Preferred Language	
Smoking Status	Please select your current smoking status (circle); Current every day smoker, Occasional day smoker, Former smoker – Please list date range you smoked _____ to _____, Never Smoked, Smoker (current status unknown, Unknown.
Do you have any allergies to medications?	If yes, what are you allergic to?
What medications do you currently take, (Both prescription and over the counter)	List medication name, strength, and dosage for each.
Pharmacy	Pharmacy Name, and Location.

Who is your medical doctor? _____ Date of last exam _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc., or injuries): _____

_____

_____

List any surgeries you have had (cataract, tonsillectomy, appendectomy): _____

_____

Do you currently have any problems in the following areas? If "YES" please provide information.

EYES	YES	NO	EXPLANATION OF PROBLEM
Glaucoma, Cataract, etc.)			
Retinal disease, Retinal detachment			
Loss of vision, or Loss of side vision			
Blurred vision, or Distorted vision (halos)			
Fluctuating Vision or Double vision			
Mucous discharge, Excess tearing, or Dryness			
Sandy, Gritty or Foreign body sensation			
Glare / light sensitive			
Eye pain, soreness, or Redness			
Eye or lid infection			
Tired eyes			
Crossed eyes, lazy eye			
Dropping eyelids			

OVER ↵

MEDICAL	YES	NO	EXPLANATION OF PROBLEM
GENERAL/CONSTITUTIONAL			
Fever, Weight loss, Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL. KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCINE (Diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (Cholesterolemia, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (Hay fever, lupus, sjogrens, etc.)			

FAMILY HISTORY **M-Mother F-Father S-Sibling GP-Grandparent**

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness or Glaucoma			
Arthritis			
Cancer			
Kidney disease			
Heart disease or high blood pressure			
Diabetes, Thyroid disease, Stroke, Lupus			
Other			

Do you have an Optometrist? YES NO Optometrist's Name_____
Do you drive? YES NO
Do you have visual difficulty when driving? YES NO
Do you have problems with night vision? YES NO
Do you currently wear contact lenses? YES NO
If YES, how long have you worn contact lenses? _____
Do you currently wear glasses? YES NO
If YES, how long have you had the current prescription? _____
Have you ever laser eye surgery? YES NO
Have you ever had refractive eye surgery? YES NO
Have you ever had a blood transfusion? YES NO
Do you drink alcohol? YES NO
If YES, Occasionally 1 per day 2-3 per day 4+ per day

SOCIAL HISTORY

Marital Status: (married, divorced, single widowed): _____
Current Occupation: _____

HISTORY REVIEWED. No Changes. Additions as noted above.

Every statement above is true and correct to the best of my knowledge.

Patient signature: _____ Date: _____

Physicians signature: _____ Date: _____

FOR OFFICE USE ONLY

EMR Complete ☐ Initial _____ Date_____