Medical History Questionnaire

Patient Name_____ Today's Date_____

Birthdate_____ **Email Address**_____

Allergies_____

Current Medications_____

_____

History of Illness/Medical Conditions_____

Diabetes __yes __no If Diabetic, Taking Insulin__ yes __no and/or Taking Oral Meds for Diabetes __yes __no

High Blood Pressure __yes __no

Patient History of Eye Disease or Problems_____

Family History of Eye Disease_____

Tobacco Use: Please check one.

___Never Smoked

___Former Smoker/**Quit Date**:_____

___Current Smokeless Tobacco User

___Current Someday Smoker

___Light Smoker (1-9 Cigs per day)

___Current Everyday Smoker ___**Packs** Per Day ___**Years** Smoking

___Heavy Tobacco Smoker ___**Packs** Per Day ___**Years** Smoking

Alcohol Use: Please check one.

___None

___Social Use Only

___1-2 Drinks daily

___Above Average Use

___Alcohol dependent

Have you been infected with any sexually transmitted disease? ___yes ___no

If Yes: ___Gonorrhea ___Syphilis ___Hepatitis ___HIV ___Other

Vision Ins_____

Policy Holder_____

Policy Holder DOB_____

Insurance ID_____

Group #_____

Medical Ins_____

Policy Holder_____

Policy Holder DOB_____

Insurance ID_____

Group #_____

Secondary Ins_____

Policy Holder_____

Policy Holder DOB_____

Insurance ID_____

Group #_____

By my signature I attest that the information I have provided is true and accurate. I will allow Walker Eye Care to verify my medications, including any information that my pharmacy or medical doctor has on file for me.

Signature _____