

Medical History Questionnaire

Name: _____ Today's Date: ____ / ____ / ____

Address: _____ Phone: _____

City: _____ Zip: _____ Work Phone: _____

Guardian (If Applicable): _____ Occupation: _____

Birth Date: ____ / ____ / ____ Social Security #: ____ / ____ / ____ Last Eye Exam: ____ / ____ / ____

Name of Medical Doctor: _____ Dr.'s Phone: _____

E-mail _____ Last Medical Exam: ____ / ____ / ____

Medical History

Do you have any allergies to medications? no yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? no yes

Do you wear glasses? no yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? no yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? yes no

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

* Please turn this form over and complete side two *

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes If yes, please describe:

Do you use tobacco products? no yes If yes, type/amount/how long: _____

Do you drink alcohol? no yes If yes, type/amount/how long: _____

Do you use illegal drugs? no yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
CONSTITUTIONAL					EARS, NOSE, MOUTH, THROAT		
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL					Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
EYES					RESPIRATORY		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		VASCULAR / CARDIOVASCULAR		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		GASTROINTESTINAL		
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		GENITOURINARY		
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		BONES / JOINTS / MUSCLES		
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		LYMPHATIC / HEMATOLOGIC		
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Anemia	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE					Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		ALLERGIC / IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>
					PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

Doctor's Signature

Date

DILATION AND PHOTOGRAPHY CONSENT

Dilation is important for the inspection of the periphery of the eye for the presence of tumors, retinal detachments, and other conditions such as floaters, flashes or spots appearing suddenly in the vision. Recording the use of dilating agents and retinal photography has become standard for determining the thoroughness of the examination. Photography is an important documentation procedure in detecting subtle changes in the retina. If not covered by your vision care plan, there will be an additional fee for Fundus Photographs and/or dilation. Please consult the front desk if you have any questions concerning fees.

Note: Due to the widening of the pupil, dilation will affect the comfort of many patients when reading (usually less than 2 hours) and create light sensitivity (usually less than 4 hours, but may last until morning). If this is going to present some functional difficulties for a patient, it may be declined or rescheduled for a more convenient time. Not all patients can be dilated effectively, and the appropriate potential for dilation will be determined by the doctor during the examination.

INITIAL ONE (1)

I ACCEPT DILATION I DECLINE DILATION
 I WOULD LIKE TO RESCHEDULE DILATION

INITIAL ONE (1)

I ACCEPT PHOTOGRAPHY I DECLINE PHOTOGRAPHY
Photography can be performed without dilation. The fee for photography is \$18.00.

GDxVCC GLAUCOMA TESTING

Dr. Ruiz is proud to provide his patients with the latest in glaucoma detection, the GDxVCC. We are one of the few offices in Killeen where this technology is available. It is our commitment to you to provide the best in eye care. Dr. Ruiz highly recommends the GDxVCC testing as part of your comprehensive eye examination to detect glaucoma.

Glaucoma is a disease that affects 67 million people worldwide. More than 3 million of those afflicted are Americans. Left untreated, glaucoma can lead to blindness. Because it often has no symptoms and causes no pain, many people are unaware that they have the disease until they experience vision loss. Dr. Ruiz feels it is vital to screen for this disease as part of a quality eye health exam.

- **Glaucoma is the leading cause of preventable blindness in the US**
- **It is estimated that millions more have glaucoma and are unaware of it**
- **For glaucoma patients with three living relatives, the chance that one of them has undiagnosed glaucoma is 27% among Caucasians, 50% among African Americans and Hispanics**

The GDxVCC, when used as part of a comprehensive eye exam, detects glaucoma six years ahead of other technologies by evaluating the actual site where the damage occurs. The exam takes less than one minute, is non-intrusive, requires no pupil dilation, and causes no discomfort. The GDxVCC is a significant breakthrough over other existing tests. The standard air-puff pressure check (tonometry) is ineffective for detecting glaucoma in one-half of patients diagnosed with the disease. Visual field testing (perimetry) is limited to measuring vision already lost to glaucoma. In just one minute, you can learn more about the health of your eyes!

Your insurance plan provides you with basic vision coverage, but does not include advanced disease detection procedures like the GDxVCC testing. The fee for this extended exam is only \$18.00.

PLEASE CHECK ONE (1)

- I ACCEPT THE GDxVCC GLAUCOMA TESTING
 I DECLINE THE GDxVCC GLAUCOMA TESTING

Patient Signature: _____ Date: _____