METROPOLITAN OPTICAL

MEDICAL HISTORY QUESTIONNAIRE FOR RETURNING PATIENTS

Name: _____ Today's Date: _____
First *Last*

Birth Date: _____ Marital Status: Single / Married Email:_____

Address: _____
Street *City* *State* *Zip Code*

Phone: (_____)_____ (_____)_____ (_____)_____
Home *Work* *Cell*

Occupation: _____ Employer: _____

Are you planning on purchasing glasses and/or contacts? Yes / No

Will you be using vision or medical insurance today? _____ Which insurance? _____

EYE CARE NEEDS

How old is your present pair of glasses? _____ How many pair of glasses do you currently use?_____
Do you wear contacts? If yes, how old is your present pair of contacts? _____ Are they comfortable? □ Yes □ No

Have you had LASIK surgery? □ Yes □ No	Are you sensitive in bright sunlight? □ Yes □ No
Do you perform fine or close-up work? □ Yes □ No	Do you have trouble reading signs when driving at night? □ Yes □ No
Are you outdoors all or part of the time? □ Yes □ No	Are you bothered by the glare from overhead lighting? □ Yes □ No
Is safety protection a concern at work? □ Yes □ No	Are you bothered by the glare from a computer screen? □ Yes □ No

Eyes	**Yes**	**No**	**Family**		**Yes**	**No**	**Family**
Loss of Vision	□	□	□	Burning	□	□	□
Blurred Vision	□	□	□	Foreign Body Sensation	□	□	□
Distorted Vision	□	□	□	Excess Tearing / Watering	□	□	□
Loss of Side Vision	□	□	□	Glare / Light Sensitivity	□	□	□
Double Vision	□	□	□	Eye Pain or Soreness	□	□	□
Dryness	□	□	□	Chronic Infection of Eye / Lid	□	□	□
Mucous Discharge	□	□	□	Sty or Chalazion	□	□	□
Redness	□	□	□	Flashes / Floaters in Vision	□	□	□
Sandy or Gritty Feeling	□	□	□	Tired Eyes / Eye Strain	□	□	□
Itching	□	□	□				

MEDICAL HISTORY: Do you currently have, or do you have a family history of any of the following conditions?

	Yes	**No**	**Family**		**Yes**	**No**	**Family**
Ocular History							
Glaucoma	□	□	□	Retinal Detachment	□	□	□
Cataracts	□	□	□	Macular Degeneration	□	□	□

Do you have any allergies to medications? If yes, explain:

_____

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

_____

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

_____

Are you currently pregnant or nursing? Yes / No

ASSIGNMENT OF BENEFITS: I request that payment of the assigned insurance be made directly to Dr. Ayalew & Associates for any services rendered. I authorize Dr. Ayalew and Associates to release my medical information to CMS and agents to assess benefits payable for related services.

Signature: _____ Date: _____