Dr. Joseph Deering History Questionnaire

All questions contained in this questionnaire can relate to your eye health.
All information is strictly confidential and will become part of your medical record.

Original Date:	

Name:		☐ M ☐ F	**DOB:**	
Employer (or school)				
Occupation (or grade)				

Race: ☐ White ☐ African American ☐ Pacific Islander ☐ Hispanic ☐ Asian

How were you referred to our office today? Knowing who we can thank for your visit is important to us.

☐ I am a previous customer of Winchester Optical
☐ Internet search: What did you search for? _____
☐ Your primary care doctor
☐ Friend/Relative
☐ Driving by our office
☐ Insurance carrier listing
☐ Facebook, Yelp, Patch, other social media

☐ Other

OCULAR HISTORY

Date of last eye exam:	**Previous or referring eye doctor:**

Do you have, or have you had, any ocular problems listed below? If yes please briefly explain. ☐ **No past ocular conditions**

☐ Glaucoma
☐ Cataracts
☐ Macular degeneration
☐ Trauma or Injury
☐ Retinal Detachment or Retinal Disease
☐ Strabismus / Amblyopia / "Lazy eye"
☐ Diabetic eye disease
☐ Dry eye syndrome or Dry Eyes
☐ Uveitis / Iritis
☐ Keratoconus
☐ Laser Surgery
☐ Other eye surgery

☐ Other Ocular Problems:

Does anyone in your family have any of the conditions listed below? If so please list their relationship to you.

☐ Blindness:
☐ Cataracts :
☐ Macular degeneration:
☐ Glaucoma:
☐ Retinal Detachment:
☐ Diabetic eye disease:
☐ Strabismus / Amblyopia / "Lazy eye":
☐ Corneal disease:
☐ Other:

Do you wear glasses?	☐ Yes	☐ No	If yes, are they for	☐ Distance	☐ Near	☐ Both
Do you wear contact lenses?	☐ Yes	☐ No				
Are there any activities where you would like to see better?						
Are there any activities that irritate or bother your eyes?						

CONTINUED ON BACK...

PERSONAL HEALTH HISTORY

Primary Care Physician:	Date of last physical exam:

Do you currently have or have you had the following health conditions? ☐ I have no current health conditions

General Health
- ☐ Headaches
- ☐ Head Trauma
- ☐ Cancer:_____
- ☐ Shingles

Endocrine
- ☐ Diabetes, Type ☐ 1 ☐ 2
  Last blood sugar reading _____
  Last HbA_1C reading _____%
- ☐ High/Low Thyroid Function

Cardiovascular
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Stroke

Skin/Integument
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Eczema

Neurologic
- ☐ Multiple Sclerosis
- ☐ Migraines

Gastrointestinal / Digestive
- ☐ Crohn's Disease
- ☐ IBS

Immunologic/Allergic
- ☐ Rheumatoid Arthritis
- ☐ Seasonal/Environmental allergies

Ear / Nose / Throat
- ☐ _____

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ Sarcoidosis

Musculoskeletal
- ☐ Osteoarthritis
- ☐ _____

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Lymphoma

Genitourinary
- ☐ Kidney Disease
- ☐ _____

Other Conditions:

Has anyone in your family ever been diagnosed or treated for any of the following health problems? If yes, please list who.

☐ High blood Pressure ☐ Heart Disease ☐ Diabetes

☐ Other:

Do you use tobacco?	☐ Every day	☐ Rarely	☐ Never	Are you a former smoker?	☐ Yes ☐ No	Year Quit:
Do you drink alcohol?	☐ Never	☐ Fewer than 15 drinks a week		☐ More than 15 drinks a week		
Do you use illicit drugs?	☐ Yes	☐ No				

Please list your prescribed drugs including birth control and over-the-counter drugs including vitamins, aspirin and inhalers. ☐ None
If you can provide your own list of medications please provide it to us and you can skip this step.

Name of the Drug	Reason for Taking	Strength	Frequency Taken

Do you have any allergies to medications? If yes, note which below. ☐ No

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

Year	Reason	Hospital/Doctor

1) We will do all we can to find out what your vision insurance benefits are and what you are eligible for. We will also submit your claim for you when possible. The information given to us by your insurance company is not a guarantee of payment from them. If your insurance company does not pay this amount it will be your responsibility to pay your balance.

2) I acknowledge that I have received and reviewed a copy of Dr. Joseph Deering's Notice of Privacy Practices.

3) I certify that the information I have reported above is correct.

Signature: _____Date: _____