Original Date:

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.

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:**

Please check any of the items below that you notice about your eyes or vision.

☐ Blurred distance vision	☐ Blurred vision during reading	☐ Double vision
☐ Squinting of excessive blinking	☐ Holds reading material very close	☐ Loses place when reading
☐ Frequent headaches	☐ Painful eyes	☐ Light sensitive eyes
☐ Red eyes	☐ Teary eyes	☐ Rubs eyes
☐ Tired or Strained eyes	☐ Avoids close work	☐ Tilts head
☐ Trouble with reading	☐ Trouble with math problems	☐ Poor hand eye coordination

Do you have, or have you had, any visual or ocular problems listed below? ☐ **No past ocular conditions**

- ☐ Strabismus (crossed or wandering eye)
- ☐ Amblyopia (“lazy eye”)
- ☐ Cataracts
- ☐ Nystagmus
- ☐ Learning disability or “dyslexia”
- ☐ Trauma or Injury
- ☐ Conjunctivitis
- ☐ Uveitis / Iritis
- ☐ 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.

- ☐ Strabismus (crossed or wandering eye):
- ☐ Amblyopia (“lazy eye”):
- ☐ High eyeglasses prescription:
- ☐ Cataracts as a child:
- ☐ Other:
- ☐ Macular degeneration:
- ☐ Glaucoma:
- ☐ Retinal Disease:
- ☐ Corneal disease:

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/chicken pox

Endocrine
- ☐ Diabetes, Type ☐ 1 ☐ 2
  Last blood sugar reading _____
  Last HbA_1C reading _____%
- ☐

Cardiovascular
- ☐ Heart Murmur
- ☐ Stroke
- ☐ Heart Disease

Skin / Integument
- ☐ Acne
- ☐ Psoriasis
- ☐ Eczema

Neurologic
- ☐ Migraines
- ☐

Gastrointestinal / Digestive
- ☐ Crohn's Disease
- ☐

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

Ear / Nose / Throat
- ☐ Frequent ear infections

Respiratory
- ☐ Asthma
- ☐

Musculoskeletal
- ☐

Hematologic / Lymphatic
- ☐ Anemia
- ☐ Lymphoma

Genitourinary
- ☐ Kidney Disease
- ☐

Other Conditions:

List any severe childhood illnesses, injuries, surgeries, and / physical impairments

Year	Reason	Hospital/Doctor

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

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: _____