



HEALTH HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name _____ First Name _____ M/F _____ MI _____
 Cell Phone _____
 Date of birth _____
 Date of Last Eye Exam _____ Dilated? Yes No

Medical Information

What is your general health? _____

Do you have problems with any of these systems? (Please circle yes or no.)

Gastrointestinal	<input type="checkbox"/> Yes/No <input type="checkbox"/>	Nervous	<input type="checkbox"/> Yes/No <input type="checkbox"/>	Endocrine (glands)	<input type="checkbox"/> Yes/No <input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/> Yes/No <input type="checkbox"/>	Urinary	<input type="checkbox"/> Yes/No <input type="checkbox"/>	Blood/Lymph	<input type="checkbox"/> Yes/No <input type="checkbox"/>
Cardiovascular	<input type="checkbox"/> Yes/No <input type="checkbox"/>	Muscles/Bones	<input type="checkbox"/> Yes/No <input type="checkbox"/>	Allergidimmunologic	<input type="checkbox"/> Yes/No <input type="checkbox"/>
Respiratory	<input type="checkbox"/> Yes/No <input type="checkbox"/>	Integumentary (skin)	<input type="checkbox"/> Yes/No <input type="checkbox"/>	Headaches	<input type="checkbox"/> Yes/No <input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> Yes/No <input type="checkbox"/>	Eyes	<input type="checkbox"/> Yes/No <input type="checkbox"/>	Mental	<input type="checkbox"/> Yes/No <input type="checkbox"/>

Please explain _____

Diabetes Yes/No Type _____ Date of diagnosis _____

AllergiestoMedication Yes/No Which? _____ Reactions? _____

Other health problems _____

Current medication(s) _____

Have you had any operations? Yes/No Kind? _____ When? _____

Name of family doctor _____

Date of last visit _____ Date of last tetanus shot _____

Family History

High blood pressure Yes/No Relation _____ Macular degeneration Yes/No Relation _____

Diabetes Yes/No Relation _____ Retinal detachment Yes/No Relation _____

Glaucoma Yes/No Relation _____ Cataracts Yes/No Relation _____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? _____

Have you had any eye operations? Yes/No Type _____ Date _____

Have you had an eye injury? Yes/No Kind _____ Date _____

Do you have glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No

Macular degeneration? Yes/No Retinal detachment? Yes/No Blurred vision? Yes/No

Do you wear glasses? Yes/No Contact lenses? Yes/No Type _____

Additional information _____

Doctor Use Only

Reviewed by _____ No changes Date _____

Reviewed by _____ No changes Date _____

Reviewed by _____ No changes Date _____

McHENRY OPTICAL, INC
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**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

The undersigned Patient or legally authorized representative (“Agent”) of the Patient acknowledges that he or she personally received a copy of the McHenry Optical’s Notice of Privacy Practices on the date indicated below.

Patient’s Name (Please Print): _____

Patient’s Signature: _____ Date: _____

Agent’s Signature: _____ Date: _____

Information about Agent

Agent (Print Name): _____

Relationship to Patient: _____