

**Montgomery Village Eye Center, Inc.**  
**Gabriela Miller, O.D.**

*This questionnaire is part of your confidential record. Please be as accurate as possible.*

Name: \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Dr.'s Phone #: \_\_\_\_\_

Last Eye Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

**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 directly with my doctor

Do you drive?  Yes  No Do you have visual difficulty while driving?  Yes  No

Do you use a computer?  Yes  No How often? \_\_\_\_\_

Do you use tobacco products?  Yes  No If yes, type/frequency? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, how much? \_\_\_\_\_

Do you use illegal drugs?  Yes  No If yes, type/frequency? \_\_\_\_\_

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

**Medical History**

Do you have allergies to medications?  Yes  No If yes, explain: \_\_\_\_\_

\_\_\_\_\_  
List any medications you take (including oral contraceptives, over the counter medications, vitamins and supplements): \_\_\_\_\_

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

\_\_\_\_\_  
Are you pregnant and/or nursing?  Yes  No

Do you wear glasses?  Yes  No If yes, how old is your present pair? \_\_\_\_\_

Do you wear contact lenses?  Yes  No If yes, how old is your present pair? \_\_\_\_\_

Type of Contact Lenses:  Rigid  Soft  Extended Wear  Other Are they comfortable?  Yes  No

**Family History**

**Please note if any family members, living or deceased, have had any of the following conditions:**

Lazy Eye  Macular Degeneration  High Blood Pressure

Glaucoma  Retinal Detachment  Cataracts

Diabetes  Blindness

Please explain any boxes that you have checked: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Review of Systems:**

**Have you ever had any problems in the following areas?**

<b>System/Condition</b>	<b>Yes</b>	<b>No</b>	<b>System/Condition</b>	<b>Yes</b>	<b>No</b>
<b>CONSTITUTIONAL</b>			<b>EYES</b>		
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>
<b>INTEGUMENTARY (skin)</b>			Chronic Infection	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Distorted Vision	<input type="checkbox"/>	<input type="checkbox"/>
<b>NEUROLOGICAL</b>			Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>
<b>EARS, NOSE, MOUTH</b>			Redness	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/ Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
<b>CARDIOVASCULAR</b>			Burning	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Watery Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
<b>GASTROINTESTINAL</b>			Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Flashes / Floaters	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	Styes	<input type="checkbox"/>	<input type="checkbox"/>
<b>GENITOURINARY</b>			<b>BLOOD/LYMPH</b>		
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
<b>RESPIRATORY</b>			Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<b>MUSCLES/BONES/JOINTS</b>		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
<b>ENDOCRINE</b>			Connective Tissue Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<b>PSYCHIATRIC</b>		
				<input type="checkbox"/>	<input type="checkbox"/>

**If you answered YES to any of the above, or have a condition not listed, please explain and list medications used for treatment:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that I have filled out the above information to the best of my knowledge.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(if patient is under 18)

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Montgomery Village Eye Center, Inc.**  
**Gabriela Miller, O.D.**

**All personal information is kept confidential in our office.**

Patient's Name: Miss/Mrs./Ms./Mr./Dr. \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # (if over 18): \_\_\_\_-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ (Your email is never shared. we use it strictly for communications.)

**Financially Responsible Party:** Name: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Best contact phone: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

<b>Name of Vision Insurance:</b>	
Policy Holder's Name:	Policy Holder's DOB:
ID Number:	Policy Holder's SS#:

<b>Name of Medical Insurance:</b>	
Policy Holder's Name:	Policy Holder's DOB:
ID Number:	Policy Holder's SS#:

**How were you referred to us? Please check all that apply.**

- Friend / Family Member: \_\_\_\_\_  Walk-by  
 Yellow Pages  Community Phone Book  Montgomery Village News  
 Insurance List  Internet Search  Other: \_\_\_\_\_

Are you interested in being fitted for contact lenses?  Yes  No

Would you like information about Laser Vision correction?  Yes  No

**FINANCIAL WAIVER AND RELEASE**

The insurance information I, \_\_\_\_\_ provided on \_\_\_\_\_, is true to the best of my knowledge. I agree to pay any co-payments, co-insurance, and deductibles as required by my insurance company for the goods and services provided. If for any reason my insurance company denies or considers any goods or services not covered under my plan, I understand that I will be financially responsible for the bill.

I authorize my insurance benefits to be paid directly to Montgomery Village Eye Center Inc. I also authorize Montgomery Village Eye Center Inc. to release any information required to my insurance company in order to process my claims.

I have read and understand the above statements.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(If patient is under 18)