GENERAL MEDICAL HISTORY QUESTIONNAIRE FOR DR. JOHNSON

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| YES NO   |  |  |  | | --- | --- | --- | | High Blood Pressure |  |  | | Diabetes |  |  | | Arthritis/Lupus/Sjogren’s |  |  | | Seasonal Allergies |  |  | | Thyroid Disease |  |  | | Heart Problems |  |  | | Asthma |  |  | | Anxiety/Depression |  |  | | Hepatitis/Liver Disease |  |  | | Kidney Problems |  |  | | Tuberculosis |  |  | | Are you Pregnant? |  |  | | High Cholesterol |  |  | |
|  |

Please list any **MEDICATIONS you take**

Do you have **ALLERGIES** to any medications? YES or NO If yes, please list

List any **EYE SURGERIES** or **EYE DISEASES** you have had (cataracts, etc.):

FAMILY HISTORY Has anyone in the immediate family been treated or informed they have any of the following?

**YES NO RELATIVE**

|  |  |  |  |
| --- | --- | --- | --- |
| Blindness, |  |  |  |
| Glaucoma |  |  |  |
| Cataract, |  |  |  |
| Macular Degeneration |  |  |  |
| Lazy/Cross eye |  |  |  |

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO**

Do you drink alcohol………..YES NO If YES, how much?

Do you smoke? ..YES NO If YES, how much?How many years?

*\*\*Your major medical insurance may be billed for your medical exam and additional testing\*\**

I authorize the release of any medical or other information necessary to determine my health care benefits or the benefits payable for related equipment or services to Dr. Johnson, HCFA, my insurance carrier, or other medical entity as determined by HIPPA. I understand that I am financially responsible for any charges not covered by my health care benefits. I am responsible for the entire bill or balance of the bill as determined by my health care insurer if the submitted claims or any part of them are denied for payment.

**\*\**I acknowledge that I received a copy of Dr. Johnson’s Privacy Policy\*\****

Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Initials\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_