Welcome to the Office of Troy A. Norton, O.D.
www.nortoneyecare.com

MEDICAL HISTORY QUESTIONNAIRE

Patient Information: (Please Print)

Patient Name ____________________ MI ________ Today's Date ____/____/____

Date of Birth ____/____/____ Sex ☐ M ☐ F Social Security Number ______-____-______

Mailing Address: ____________________ Physical Address ____________________

City ____________________ State ____________ Zip ____________

Home Phone ____________ Cell____________ Work ____________

E-mail Address ____________________

Communication Preference: ☐ Mail ☐ Email ☐ Text ☐ Phone Employer ____________________

Occupation ____________________ Married ☐ Yes ☐ No Spouse's Name____________________

Primary Care Physician ____________________ Name of Optometrist seen previously ____________________

Insurance (Medical) ____________________ (Vision) ____________________

Subscriber's Name ____________________ Subscriber's Date of Birth ____/____/____

Subscriber's Social Security Number ______-____-______ Subscriber's Employer ____________________

Subscriber's Address ____________________

Name of Legal Guardian/Responsible party (if patient is a minor) ____________________ *D.O.B.* ____________

Relationship to patient ____________ *Address if different than patient* ____________________

SOCIAL HISTORY

Do you currently smoke? ☐ Yes ☐ No Have you previously smoked? ☐ Yes ☐ No When did you quit? ____________

If yes, how long have you smoked? ____________ Packs per day: ____________

HEALTH HISTORY **Height:** ____________ **Weight:** ____________

Are you currently experiencing any of the following?

Loss or change of vision	No	Yes
Blurry Vision	No	Yes
Injury to affected eye	No	Yes
Pain or irritation	No	Yes
Watery eyes	No	Yes
Discharge	No	Yes
Discoloration of eye	No	Yes
Flashes or Floaters	No	Yes

Other ____________________

Do you wear glasses?	No	Yes

If yes, how old are they? ____________________

Do you wear Contacts?	No	Yes

If yes, Brand and prescription ____________________

____

Do you have a history of any of the following?

Cataracts	No	Yes	
Glaucoma	No	Yes	
Retinal Detachment	No	Yes	
ANY Eye Surgery	No	Yes	Explain ____________
Iritis/Inflammation	No	Yes	
Corneal Disease	No	Yes	
Eye Injury	No	Yes	Explain ____________
Macular Degeneration	No	Yes	
Diabetic Retinopathy	No	Yes	
Dry Eyes	No	Yes	
Eye Pain	No	Yes	
Flashes or Floaters	No	Yes	
Halos	No	Yes	
Glare Sensitivity	No	Yes	
Allergies	No	Yes	

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Personal Medical History:

Endocrine

Diabetic No Yes Type ____________________ Date of Diagnosis ______________________

Thyroid No Yes

Cardiovascular			**Bones/Joint/Muscles**			**Respiratory**		
High blood pressure	No	Yes	Joint Pain/Arthritis	No	Yes	Asthma	No	Yes
Heart Disease	No	Yes	**Lymphatic**			Emphysema	No	Yes
Heart Attack	No	Yes	Bleeding Problems	No	Yes	**Allergic**		
Stroke	No	Yes	**Psychiatric**			Seasonal Allergies	No	Yes
Cholesterol Issues	No	Yes	Depression	No	Yes	**Ears/Nose/Throat**		
Gastrointestinal			**Neurological**			Congestion	No	Yes
Stomach	No	Yes	Headaches	No	Yes	Chronic Cough	No	Yes

Other: ____

____

Allergies to medications No Yes If yes, which ones ____

Current Medications (***if you have a list, please feel free to give that to the receptionist instead of writing them out***)

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Have you had any operations? No Yes Kind? ____________________ When ____________________

____________________ ____________________

Family History

High Blood Pressure	No	Yes	Relationship to you ____________________
Diabetes	No	Yes	____________________
Glaucoma	No	Yes	____________________
Macular Degeneration	No	Yes	____________________
Retinal Detachment	No	Yes	____________________
Cataracts	No	Yes	____________________

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I authorize Dr. Troy A. Norton O.D. or my insurance company to release any information needed to process my claims. I understand that I am financially responsible for any co pay, co-insurance, deductible, and other non covered services or materials the day services are rendered. I also understand I am financially responsible for any balance remaining after my claim has been processed.

Patient/Guardian Signature ____ Date ______/______/______

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge I have been offered or received a copy of this practice's NOTICE OF PRIVACY PRACTICES. Private pay patients have the right to instruct Dr. Norton not to share information about treatment to their insurance company.

I do _____ I do NOT _____ wish to have information about my treatment shared with my insurance company.

Patient/Guardian Signature ____ Date ______/______/______