Jackson
VISION CLINIC

Today's Date: ______________________

Medical History Questionnaire

Account No.:

Personal Information

Patient Last	First	Middle	
Spouse Last	First	Middle	
Address	City	State	Zip
Phone (H)	(W)	Gender M F	Marital Status S M other
DOB	Age	SSN	
Employer	Phone	Your Position	
Primary Vision Insurance		Patient ID No.	
Secondary Vision Insurance		Patient ID No.	
Primary Care Doctor		Last Visit	

Eye Information (please check yes or no)

	YES	NO
Do you have blurred vision?		
Do you have any eye injuries?		
Have you had any eye surgery? If so, when______________		
Do you have Glaucoma?		
Do you have Cataracts?		
Do you have Dry Eyes?		
Do you wear glasses?		
Do you wear contact lenses?		
Do you use a computer terminal? If so how much?__________		
Do you have other eye problems or disease?		

Medical Information

Do you have problems with any of these systems? (Please circle the ones that apply to you)

Gastrointestinal	*Nervous system*	*Mental Health*
Ears/Nose/Throat	*Genitourinary*	*Endocrine (glands)*
Cardiovascular	*Musculoskeletal*	*Blood/Lymph*
Respiratory	*Integumentary (skin)*	*Allergic/Immune*

	YES	NO
Do you have diabetes?		
Do you have headaches		
Are you allergic to any medications?		
Are you pregnant? If so, how far?________months		

Please list all current medications, herbs, and vitamins (prescriptin and non-prescription) that you're taking right now:____

Social History

	YES	NO
Do you smoke?		
Do you drink alcohol?		
Have you used or are you using any substances right now?		

What are your hobbies?____

Family History

	YES	NO
Does any of your family member have diabetes (If so, relation?________________)		
Does any of your family member have high blood pressure (If so, relation?____________)		
Does any of your family member have Glaucoma (If so, relation?________________)		
Does any of your family member have Macular Degeneration?		
Does any of your family member have Retinal Degeneration?		
Does any of your family member have Migrate Headache?		
Does any of your family member have other medical conditions not listed here?		

Release of Information

I ______________________ hereby request you send my records JACKSON VISION CLINIC, INC.
225 12th Avenue South - Suite 103
Seattle, WA 98144
Busines: (206) 322-6915
Fax (206) 322-6914

Patient ______________________ DOB ____________

Address ______________________ Phone ____________

Signature ______________________ Date ____________

By signing this release of information, you also authorize JACKSON VISION CLINIC, INC. to release any information required to process insurance claims.

We will be billling your insurance once service has been provided. However, if we do not receive payment in full from your insurance company you will be responsible for the remaining balance of the bill.

Thank you for choosing JACKSON VISION CLINIC, INC.