

WELCOME TO THE OFFICE OF DR. JANUARY L. MOENNIG



Please answer the following questions:

Today's Date_____

Date of Birth_____

Full Name_____ Social Security_____

Address_____ Lot/Apt #_____

City_____ State_____ Zip Code_____

Telephone_____ Work/Cell _____

Occupation_____ Place of Employment_____

Email Address_____

Spouse/Companion's Name_____

If you are a minor, the name of parent/guardian_____

Your primary care physician's name_____

When was your last physical examination?_____ Eye Exam?_____

How did you hear about our office?_____

Please circle the following which applies best:

I have glasses that are: single vision bifocals trifocals progressives none

I currently wear contact lenses that are: soft disposable gas perm hard

Do you remove your contacts? Daily Weekly More than a week

If you do not wear contact lenses, are you interested in being fitted with them_____?

Any current symptoms you are experiencing but have not been diagnosed yet?_____

In the future if you should have an emergency such as an eye infection or injury, please call our office. If necessary, we will see you immediately. **AFTER HOURS, THERE IS AN EMERGENCY TELEPHONE NUMBER ON OUR TELEPHONE RECORDER.**

Payment policies: We accept cash, checks, Master Card, Visa and Discover. We take assignment for Medicare and Medicaid, otherwise we will be happy to provide you with an itemized receipt to turn into your healthcare provider.

We thank you for choosing our office for your eye care needs. In the future, if you have any questions regarding your examination or prescription, please do not hesitate to call.

Dr. January Moennig and Staff

Medical History Questionnaire

Name of Medical Doctor: _____ Dr.'s Phone: _____

Last Medical Exam: ____/____/____

Medical History

Do you have any allergies to medications? no yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

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

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? no yes

Do you wear glasses? no yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? no yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? yes no

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 information directly with my doctor. (Check box)

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes If yes, please describe:

Do you use tobacco products? no yes If yes, type/amount/how long: _____

Do you drink alcohol? no yes If yes, type/amount/how long: _____

Do you use illegal drugs? no yes If yes, type/amount/how long: _____

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

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
CONSTITUTIONAL					EARS, NOSE, MOUTH, THROAT		
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL					Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
EYES					RESPIRATORY		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		VASCULAR/CARDIOVASCULAR		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		GASTROINTESTINAL		
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		GENITOURINARY		
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		BONES/JOINTS/MUSCLES		
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		LYMPHATIC/HEMATOLOGIC		
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Anemia	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE					Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>
					PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

Doctor's Signature

Date