MASHPEE VISION CARE

681 FALMOUTH ROAD, UNIT B-12
MASHPEE, MA 02649
508-477-1802

Welcome to the office of Dr. B. Lynne Grove, Doctor of Optometry.
Please complete this two-page form, so that we can better assist you with your eye care needs.

Name: _____ Birth Date: _____
Address: _____ Email: _____
Home Phone: _____Work Phone: _____ Cell Phone: _____
Medical Insurance: _____ Vision Insurance: _____
Subscriber: _____ ID or SS#: _____ Occupation: _____
Employer: _____ Address: _____
Patient's relationship to subscriber: Self Spouse Former Spouse Domestic Partner Child Other
How did you hear about our office, we would like to thank them: _____

ASSIGNMENT_AND_RELEASE

I authorize payment of benefits directly to Dr. B. Lynne Grove for services rendered. I also authorize release of any medical information that may be required in determination of such benefits. I understand that some services may require approval of my primary care physician for coverage and that, if I do not obtain that approval, I am financially liable for services. I understand that my insurance carrier may not cover some services or products, and that benefits information does not constitute approval of payment. I understand that it is my responsibility to understand the benefits, services, and products covered by my individual policy. Deductibles and Fees not paid by my insurance carrier will be my responsibility.
Signature: _____Date: _____

MEDICAL HISTORY QUESTIONNAIRE

FAMILY/PERSONAL HISTORY- Please review the questions below, and mark all answers that apply.
What Problems have you experienced, or are you currently experiencing with your eyes?

Blurred Vision
Distorted Vision/Halos
Loss of Side Vision
Loss of Central Vision
Double Vision
Flashes
Floating Spots
Blindness
Retinal Detachment
Macular Degeneration
Retinal Disease

Redness
Burning
Itching
Dryness
Tired Eyes
Excessive Tearing/Watering
Problems with Contact Lenses
Crossed Eyes
Diabetic Eye Diseases
Glaucoma

Mucous Discharge
Foreign Body Sensation
Sandy or Gritty Feeling
Chronic Eye/Lid Infections
Sties or Chalazions
Eye Pain or Soreness
Crusting on Eyelashes
Glare/Light Sensitivity
Cataracts
Lazy Eye

Do any blood relatives have any of the following eye or medical conditions? What is their relationship to you?

	Relationship		Relationship
Arthritis	_____	Blindness	_____
Cancer	_____	Cataracts	_____
Diabetes	_____	Crossed Eyes	_____
Heart Disease	_____	Glaucoma	_____
High Blood Pressure	_____	Macular Degeneration	_____
Kidney Disease	_____	Retinal Detachment	_____
Thyroid Disease	_____	Retinal Disease	_____
Amblyopia (Lazy Eye)	_____	Other Condititions:	_____

REVIEW OF SYSTEMS- Please review the questions below, and circle all answers that apply.

Do you have any of the following medical conditions?

Heart Disease	Asthma	Cancer
High Blood Pressure/Cholesterol	Allergies or Hay Fever	Anemia
Heart or Chest Pain	Chronic Bronchitis	Bleeding Disorder
Vascular Disease	Chronic Cough	Diabetes
Arthritis	Emphysema	Diarrhea or Constipation
Fibromyalgia	Runny Nose	Depression/Psychiatric Issues
Lyme Disease	Sinus Congestion	Dry Throat or Mouth
Lupus	Headaches	Fever
Psoriasis or Rosacea	Migraine	Kidney or Bladder Disease
Thyroid Disease	Stroke or Seizures	Weight Gain or Loss

Other: _____
_____

SOCIAL HISTORY

Do you drive? Yes No Do you have visual difficulty when driving? Yes No
Do you consume alcohol? Yes No If yes, type/amount/how long: _____
Do you use tobacco products? Yes No If yes, type/amount/how long: _____
Have you been exposed/infected with: Hepatitis HIV Gonorrhea/Syphilis Other: _____
Marital/Living status: Single Married Widowed Live Alone Live with family/friends

MEDICAL HISTORY

Please list all medications and supplements you are taking. We will be happy to photocopy your written list.
_____
_____

Who is your primary care physician? _____
Phone Number? _____ When was your last physical exam? _____
Are you pregnant? _____ Are you postpartum? _____, How long? _____ Are you nursing? _____
Please list any medications that you are allergic to: _____

List all major surgeries, injuries, or illnesses you have had in the past 10 years. _____
_____
_____

Do you wear glasses? Yes No If yes, how old are they? _____ Is this the most recent Rx? Yes No
Do you wear contacts? Yes No If yes, how old are they? _____ Is this the most recent Rx? Yes No
If yes, what type of contacts do you wear? Rigid Soft Other Are they comfortable? Yes No
If yes, how often do you replace them? Annually Monthly Biweekly Weekly Daily
If no, do you wish to be fitted for contacts? Yes No Would you like colored contacts? Yes No

Thank you for completing our medical history form.
Each time you visit the office for a routine exam, you will be asked to review this information.
Please make any changes directly on the form, then date and initial on the lines below.

_____	_____	_____	_____	_____	_____	_____
Initials/Date	Initials/Date	Initials/Date	Initials/Date	Initials/Date	Initials/Date	Initials/Date

For Office Use

Doctor's Signature _____ Date _____

Reviewed by Doctor

_____	_____	_____	_____	_____	_____	_____
Date	Date	Date	Date	Date	Date	Date