Patient History Questionnaire

DATE: ___________________

Welcome to our office! We want to provide you with the very best in vision care. We realize your time is valuable and our staff will try to attend to you as quickly as possible. In order for us to serve you better, we need certain biographical information from you. Please complete the following data for our records. (PLEASE PRINT)

PATIENT INFORMATION

Last Name ________________________ Suffix ____ First Name ________________________ Middle Initial ____
Gender: __________________
Name you prefer to be called (if different than first name) ________________________
Mailing Address ________________________
City ________________________ State __________ Zip __________
Social Security # ________________________ Date of Birth ______/______/______
Employer: ________________________ Occupation: ________________________
Home # (_____)__________ Cell # (_____)__________ Work # (_____) __________
Email ________________________
Whom may we thank for referring you to us? ________________________
Emergency Contact ________________________ Phone __________
Preferred language ______English ______Spanish ______French ______Japanese ______Declined to Specify
Race ______American Indian/Alaska Native ______Asian ______Black or African American ______Hispanic
______Native Hawaiian or other Pacific Island ______White ______Declined to Specify
Ethnicity ______Hispanic or Latino ______not Hispanic or Latino ______Native American/other Pacific Island
______Declined to Specify
Communication Preference ______Email ______Postal ______Telephone
Preferred Pharmacy ________________________

RESPONSIBLE PARTY ***(If different than the patient, please complete the following.)***

Last Name ________________________ Suffix ____ First Name ________________________ Middle Initial ____
Mailing Address ________________________
City ________________________ State __________ Zip __________
Home # (_______)__________ Work # (_______)__________
Email ________________________ Social Security # __________

INSURANCE INFORMATION

Insurance Company: ________________________ Primary Policy Holder: __________
Patient's Relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Child
Policy Holder's Date of Birth: ________________________

I authorize any holder of medical or other information about me to release to the S/S administration or any other carriers any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits either to myself or to the party who accepts assignment below. I understand that I am responsible for any costs in excess of the benefits payable by my insurance plan.

Patient's Signature: ________________________ Date: __________

EYE HEALTH HISTORY

Date of last exam: ________________________ Doctor: ________________________
Do you currently wear glasses: Yes No How old are your glasses: __________
Have you ever worn contacts? Yes No Do you currently wear contacts? Yes No
Describe any problems with your contacts: ________________________
Are you interested in wearing contact lenses? Yes No

Please circle to indicate if you have had any of the following:

Blurred Vision Near	Discharge from Eyes	Floaters, Spots	Loss of Vision
Blurred Vision Far	Double Vision	Fluctuating Vision	Migraine Headaches
Burning Eyes	Dry Eyes	Headaches	Red Eyes
Color Vision, Poor	Eye Injury	Itching Eyes	Seeing Halos
Crossed Eyes	Eye Strain	Light Sensitive	Seeing Flashes
Watering Eyes	Vision Poor		Temporary Loss of Vision

MEDICAL HISTORY

Primary Care Physician ______________________________

Do you have allergies to medications? Yes No If so please list: ________________________

____

List any medications that you take: ______________________________

____

List all surgeries you have had: ______________________________

____

Pneumonia Vaccination__________ Date:_______ Flu Vaccination__________ Date:_______

Are you pregnant or nursing?_____Yes_____No

REVIEW OF SYSTEMS

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

Please check yes or no

	YES	NO
Skin Disease/Skin Cancer	☐	☐
Breast Cancer	☐	☐
Arthritis	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Paralysis	☐	☐
Hypothyroidism	☐	☐
Hyperthyroidism	☐	☐
Diabetes	☐	☐
Asthma	☐	☐
Chronic sinus problems	☐	☐
Hearing Loss or injury	☐	☐
Prostate cancer	☐	☐
Kidney Disease	☐	☐
Cervical/Ovarian Cancer	☐	☐
Seasonal	☐	☐
Heart Attack	☐	☐
Heart failure	☐	☐
Anemia	☐	☐
Bleeding disorder	☐	☐
Depression	☐	☐
COPD	☐	☐
GERD	☐	☐
Stroke	☐	☐
High Blood Pressure	☐	☐
HIV/AIDS	☐	☐

If you answered yes to any of the above or have a condition not listed, please list:

FAMILY MEDICAL HISTORY

Please circle any medical disease that runs in your immediate family

Diabetes High Blood Pressure Cataracts Glaucoma Macular Degeneration

Other ____

SOCIAL HISTORY

Do you drive? Yes No

Are you a current smoker? Yes No If yes, type/amount/how long? ____________

Do you drink alcohol? Yes No If yes, type/amount/how long? ____________

Do you use illegal drugs? Yes No If yes, type/amount/how long? ____________

Dr's Initials ________ Date ______________