

**PATIENT HISTORY QUESTIONNAIRE - Please answer all questions**

Last Name (Mr. Mrs. Ms. Miss) \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ S.S.N. \_\_\_\_\_ Date of birth \_\_\_\_\_ E-mail (optional) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Date of last eye exam \_\_\_\_\_ Dilated? Y/N \_\_\_\_\_ Referred By \_\_\_\_\_

Spouse Name \_\_\_\_\_ Date of birth \_\_\_\_\_

S.S.N. \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone Number \_\_\_\_\_

**IF MINOR** Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Father's S.S.N. \_\_\_\_\_ Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Mother's S.S.N. \_\_\_\_\_ Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Student: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_

**MEDICAL INFORMATION** What is your general health? \_\_\_\_\_

Do you have problems with any of these systems? **Please circle Yes or No to all the following questions:**

Gastrointestinal	Y/N	Nervous	Y/N	Headaches	Y/N	Allergic/immunologic	Y/N
Ears/Nose/Throat	Y/N	Urinary	Y/N	Respiratory	Y/N	Endocrine (glands)	Y/N
Cardiovascular	Y/N	Muscles/Bones	Y/N	Blood/lymph	Y/N	Mental	Y/N
Integumentary (skin)	Y/N	High Blood Pressure	Y/N				

Please explain \_\_\_\_\_

Diabetes Y/N Type \_\_\_\_\_ Date of diagnosis \_\_\_\_\_

Allergies to Medication Y/N Allergic to what? \_\_\_\_\_ What happens? \_\_\_\_\_

Current medication(s) \_\_\_\_\_ Check if none

Have you had any operations? Y/N What Kind? \_\_\_\_\_ When? \_\_\_\_\_

Name of family doctor \_\_\_\_\_ Date of last visit \_\_\_\_\_

**FAMILY HISTORY** High blood pressure Y/N Relation \_\_\_\_\_ Macular degeneration Y/N Relation \_\_\_\_\_

Diabetes Y/N Relation \_\_\_\_\_ Retinal detachment Y/N Relation \_\_\_\_\_

Glaucoma Y/N Relation \_\_\_\_\_ Cataracts Y/N Relation \_\_\_\_\_

**PERSONAL EYE INFORMATION** Purpose of this visit \_\_\_\_\_ Specific Problem \_\_\_\_\_

Have you had any eye operations? Y/N Type \_\_\_\_\_ Date \_\_\_\_\_

Have you had an eye injury? Y/N Kind \_\_\_\_\_ Date \_\_\_\_\_

Do you have any of the following: Glaucoma Y/N Cataracts Y/N Dry eyes Y/N

Macular degeneration Y/N Retinal Detachment Y/N Blurred vision Y/N

Do you wear glasses? Y/N Contact lenses? Y/N Type \_\_\_\_\_

**VISION INSURANCE INFORMATION**

Member Name \_\_\_\_\_ Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Phone # \_\_\_\_\_

Member I. D. # \_\_\_\_\_ Group # \_\_\_\_\_ Medicaid # \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

Member Name \_\_\_\_\_ Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Phone # \_\_\_\_\_

Member I. D. # \_\_\_\_\_ Group # \_\_\_\_\_ Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

**PLEASE PRESENT ALL INSURANCE AND MEDICAL CARDS TO THE RECEPTIONIST AS COPIES WILL BE MADE FOR OUR FILES**

The above information is correct and accurate to the best of my knowledge. Any and all amounts not covered by my insurance will be my responsibility and will be paid upon receipt of statement from this office.

**Signature** \_\_\_\_\_ **Dated** \_\_\_\_\_

Doctors Initials \_\_\_\_\_