PATIENT HISTORY QUESTIONNAIRE

(Required by Insurance Carriers and must be updated at each visit)

Patient **Last Name**__________________ **First Name**________________ MI___________ **Date of Birth**_____/_____/______

EMAIL __________________________

Address______________________________ APT #______________ City_______________________ State/Zip Code______________

Cell Phone _______________________________ Home Phone ________________________Work/Other#)_________________________

If Child, Parent's Name __________________________Emergency Contact Name____________________Phone_____________________

Patient's Occupation ________________ ________ Patient's Employer (or if minor, Parent's Employer) ______________________________

Social Sec. No. ____-____-_______ Primary Vision Coverage ____________________Secondary /Medical Plan Coverage______________

Date of Last Eye Exam __________ **Refer By**/Whom Should We Thank to/How did you find out about us__________________________

Medical Information

How is your general health? _________________ Any Eye Concern/Problem____

Name of Family Doctor ______________________ Date of last visit _______ Name of Medical Insurance/Plan?__________ HMO/PPO?

Do you have any problem for any of these systems? (Please circle yes or no and All that apply)

Cholesterol	Yes / No	Nervous	Yes / No	Mental	Yes / No
Ears/ Nose/ Throat	Yes / No	Genitourinary	Yes / No	Endocrine (Glands)	Yes / No
Cardiovascular/Heart	Yes / No	Muscle/Bones	Yes / No	Blood/ Lymph	Yes / No
Respiratory	Yes / No	Integumentary (Skin)	Yes / No	Allergic / Immunologic	Yes / No

Further explain if needed______________________________ ___________Disability? Cause ___________________Since______________

Hypertension Yes / No Date of Diagnosis______________

Diabetes Types_____ Yes / No Date of Diagnosis ______________

Other health problems ____

Allergies Yes / No Allergic to what___________ Reaction / What had happened? ______________________________

Medication(s) Allergy Yes / No Which?_________________ Reaction / What had happened?________________________________

Current Medications (dosage if know / see list [__]) ____

____

Have you had any Operations? Yes / No Explain ________________________________ When? _____________________________

Do you use Cigarettes / Tobacco Yes / No__ Alcohol? Yes / No / Social only__ Recreational Substance? Yes / No / Explain___________

Family History

High Blood Pressure	Yes / No	Relation ______________	Macular degeneration	Yes / No	Relation __________________
Diabetes	Yes / No	Relation ______________	Retinal detachment	Yes / No	Relation ___________________
Cancer/What _____	Yes / No	Relation ______________	Cataracts	Yes / No	Relation ___________________
Other(s)____________________		Relation_______________	Glaucoma	Yes / No	Relation ___________________

Personal Eye Information

Do you wear glasses currently/previously? Yes /No Contact Lenses? Yes / No Type____

Have you had any eye operations? Yes / No When:_______ Any Eye Injury? Yes / No When: ___________________

Explain____

Do you have: Blur Vision? Yes / No Glaucoma? Yes / No Since________ Dry Eyes? Yes / No

Double Vision? Yes / No Cataract? Yes / No Since________ Macular Degeneration? Yes / No Since______

Patient, Parent/Guardian's Signature _______________________________ **Date:** ________ **Reviewed by/Doctors Initials**________

[ ]reviewed by Patient/Parent Signature ___________________________ **Date:** ________ **Reviewed by/Doctors Initials**________

[ ]reviewed by Patient/Parent Signature ____________________________ **Date:** _________ **Reviewed by/Doctors Initials**________