PATIENT HISTORY QUESTIONNAIRE

(must be updated at each visit)

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ City:_____ State:_____ Zip:_____

Telephone (H): _____ (W): _____ (C):_____

Email:_____ SSN: _____ Date of Birth: _____

Marital Status: O Married O Single O Other

Occupation:_____ Employer:_____

Emergency Contact/Telephone No:_____

Date of last eye exam:_____ Dilated?_____ Today's Date:_____

MEDICAL INFORMATION

What is your general health?_____

Do you have problems with any of these systems? *(please circle all that apply)*

Gastrointestinal	OY/NO	Nervous	OY/NO	Eyes	OY/NO
Ears/Nose/Throat	OY/NO	Genitourinary	OY/NO	Mental	OY/NO
Cardiovascular	OY/NO	Musculoskeletal	OY/NO	Endocrine (glands)	OY/NO
Respiratory	OY/NO	Integumentary (skin)	OY/NO	Blood/lymph	OY/NO
				Allergic/immunologic	OY/NO

Please explain:_____

Please answer all that apply:

Diabetes OY/NO Type_____ Date of diagnosis_____

Allergies OY/NO Allergic to what?_____ What happens?_____

Medication allergy OY/NO What happens?_____ Headaches OY/NO

Other health problems:_____

Current medication(s):_____

Have you had any operations? OY/NO Kind?_____ When?_____

Do you use cigarettes/tobacco?_____ Alcohol?_____ Other substance(s)? _____

Name of family doctor:_____ Date of last visit:_____

Date of last tetanus shot:_____

Height:_____ Weight:_____ Pregnant:_____ Breastfeeding:_____

FAMILY HISTORY

High blood pressure	OY/NO Relation_____	Macular degeneration	OY/NO Relation_____
Diabetes	OY/NO Relation_____	Retinal detachment	OY/NO Relation_____
Glaucoma	OY/NO Relation_____	Cataracts	OY/NO Relation_____

Other eye condition(s) OY/NO What Kind?_____ Relation _____

PERSONAL EYE INFORMATION

Have you had any eye operations? OY/NO Type_____ Date_____

Have you had an eye injury? OY/NO Kind_____ Date_____

Do you have glaucoma? OY/NO Cataracts? OY/NO Dry eyes? OY/NO Blurred vision? OY/NO

Other eye problems? OY/NO What kind?_____

Do you wear glasses? OY/NO Contact lenses? OY/NO Type_____

Interested in learning about Lasik? OY/NO

Additional information:_____

Whom may we thank for referring you? _____ Doctor's initials_____

The following person/persons have the right to access my medical and financial history.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

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:_____