Welcome to Our Office

CONFIDENTIAL

Please answer all questions on this patient questionnaire form. Date: _____

Last name: _____ First name: _____ MI: _____

Date of Birth: _____ Gender: ❑ Male ❑ Female Social Security Number: _____

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

Phone: (H) _____ (W) _____ (C) _____

Vision insurance: _____ Medical insurance: _____

Family Doctor: _____ Family Doctor's phone: _____

Occupation: _____ Last eye exam: _____ Last physical exam: _____

PERSONAL AND FAMILY MEDICAL AND EYE HISTORY

Do you or any member of your family have, or have had, any problems in the following areas? (Y = Yes, N = No)

	ME	FAMILY		ME	FAMILY
Diabetes:	❑Y ❑N	❑Y ❑N	Bleeding Problems:	❑Y ❑N	❑Y ❑N
High blood pressure:	❑Y ❑N	❑Y ❑N	Hepatitis:	❑Y ❑N	❑Y ❑N
Heart Problems:	❑Y ❑N	❑Y ❑N	HIV or Aids:	❑Y ❑N	❑Y ❑N
Cholesterol:	❑Y ❑N	❑Y ❑N	Allergies:	❑Y ❑N	❑Y ❑N
Asthma:	❑Y ❑N	❑Y ❑N	Lazy eye:	❑Y ❑N	❑Y ❑N
Arthritis:	❑Y ❑N	❑Y ❑N	Glaucoma:	❑Y ❑N	❑Y ❑N
Thyroid:	❑Y ❑N	❑Y ❑N	Macular Degeneration:	❑Y ❑N	❑Y ❑N
Venereal Disease:	❑Y ❑N	❑Y ❑N	Cataracts:	❑Y ❑N	❑Y ❑N
Do you smoke:	❑Y ❑N		Are you pregnant:	❑Y ❑N	
History (HX) of alcohol abuse:	❑Y ❑N		HX of substance abuse:	❑Y ❑N	

Please list all medication(s) that you are currently taking: ❑None _____

_____

Please list allergies to all prescription and non-prescription medications and what happens: ❑None _____

_____

PERSONAL EYE HISTORY

Have you had any previous eye surgery? ❑Y ❑N If yes, date and type: _____

Have you had any previous eye injuries? ❑Y ❑N If yes, date and type: _____

Previously had your eyes dilated? ..... ❑Y ❑N If yes, any significant side effects? _____

Reason for today's examination? _____

Do you have blurred vision? ..... ❑Y ❑N If yes, at what distance(s): ❑Far ❑Close ❑Far and Close

Do you currently wear contact lenses? ❑Y ❑N If yes, please check all that apply below and list solutions used:

- ❑Soft ❑Rigid Gas-Permeable ❑Disposable ❑Astigmatism ❑Bifocal ❑Overnight
- Solutions used: _____

ATTESTATION

I have read and understand, to the best of my knowledge, the above information. I certify that all statements are truthful and accurate. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I understand that I am financially responsible for any service considered non-covered, any deductibles and/or co-payments as well as any service denied due to non-participating provider.

_____ _____

Parent or Guardian Signature Date

CERTIFICATION: ATTENDING PHYSICIAN HAS REVIEWED THE ABOVE MEDICAL/EYE HISTORY

Attending physician signature: _____

ATTESTATION: THERE IS NO CHANGE IN MY MEDICAL/EYE INFORMATION SINCE MY LAST VISIT

Signature: _____ *Date:* _____ *Signature:* _____ *Date:* _____