PATIENT HISTORY QUESTIONNAIRE

UPDATED 10/2012

PATIENT INFO:

SALUTATION: MR / MRS / MS / MISS / DR SEX: M / F DOB:___/___/____

WHO MAY WE THANK FOR THIS REFERRAL?:_____

LAST:_____FIRST:_____ MIDDLE INITIAL: ___

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PH:_____ WORK PH:_____ CELL PH:_____

EMAIL:_____ MARITAL STATUS:_____ OCCUPATION:_____

COMMUNICATION PREFERENCE: CELL / WORK / HOME / ANY

RACE (OPTIONAL): __ AMERICAN INDIAN OR ALASKA NATIVE __ ASIAN __ BLACK OR AFRICAN AMERICAN __WHITE __NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER __ OTHER __ DECLINE TO ANSWER

ETHNICITY (OPTIONAL):__ HISPANIC OR LATINO / __ NOT HISPANIC OR LATINO / __ OTHER / __ DECLINE TO ANSWER

INSURANCE INFORMATION:

PRIMARY VISION INSURANCE: VSP / DAVIS / MESC / HUMANA / METLIFE / OTHER:_____

PRIMARY MEMBER : LAST_____ FIRST _____ DOB:_____ LAST 4 SSN:_____

MEMBER ID #:_____ RELATIONSHIP TO PRIMARY MEMBER:_____

MEDICAL INFORMATION:

DATE OF LAST EYE EXAM: _____ DILATED? YES / NO ALLERGIES:_____

ALLERGIES TO MEDICATIONS?:_____ CURRENT MEDICATIONS:_____

_____

DO YOU HAVE ANY PROBLEMS WITH ANY OF THESE SYSTEMS? (PLEASE CIRCLE YES OR NO)

GASTROINTESTINAL: YES / NO **GENITOURINARY:** YES / NO **EAR, NOSE, MOUTH, THROAT:** YES / NO

RESPIRATORY: YES / NO **MUSCULOSKELETAL:** YES / NO **INTEGUMENTARY:** YES / NO

NEUROLOGICAL: YES / NO **PSYCHIATRIC:** YES / NO **ENDOCRINE:** YES / NO

HEMATOLOGIC/LYMPHATIC: YES / NO **ALLERGIC/IMMUNOLOGIC:** YES / NO

SOCIAL HISTORY:

DO YOU SMOKE TOBACCO? YES / NO

DO YOU DRINK ALCOHOL? YES / NO

DO YOU USE RECREATIONAL DRUGS? YES / NO

CONTINUED ON BACK ------ ---------→

Personal Eye Information:

Do you have any eye conditions or problems? Yes / no What kind?_____

Have you had any eye operations? Yes / no type:_____ date: _____

Have you had an eye injury? Yes / no type: _____ date:_____

Do you have glaucoma? Yes / no Cataracts? Yes / no Dry Eyes? Yes / no

Macular Degeneration? Yes / no Retinal Detachment? Yes / no Blurred Vision yes / no

Do you wear glasses? Yes / no Contact Lenses? Yes / no
type:_____

Family History:

Glaucoma: yes / no relation:_____ Cataracts: yes / no relation:_____

Macular degeneration yes / no relation:_____ Retinal Disease: yes / no relation:_____

Blindness: yes / no relation:_____ Diabetes: yes / no relation:_____

Cancer: yes / no relation:_____ Heart Disease: yes / no relation:_____

Hypertension: yes / no relation:_____ High Cholesterol: yes / no relation:_____

Stroke: yes / no relation:_____ Other:_____ relation:_____

I understand that I am responsible to pay for all services rendered by this office at the time it is rendered. I also understand that in the event my insurance does not pay for the billed services, I will be responsible for the payment of the services in a prompt manner.

Print Patient Name (parent/guardian if minor):_____

Signature:_____ Date:_____