PATIENT HISTORY QUESTIONNAIRE

Dr. Mr. Mrs. Ms. Miss
Date: _____
Last name _____ First name _____ MI _____
Address _____ City _____ Zip _____
Telephone (H) _____ (W) _____
SSN _____ Date of birth _____
Occupation _____ Employer _____
Whom may we thank for referring you? _____

MEDICAL INFORMATION

What is your general health? _____
Do you have problems with any of these systems? *(Please circle all that apply)*

Gastrointestinal	Nervous	Mental	Eyes
Genitourinary	Endocrine (glands)	Cardiovascular	Ears/Nose/Throat
Blood/lymph	Integumentary (skin)	Allergic/immunological	Musculoskeletal
			Respiratory

Please explain _____

Please answer all that apply:

Diabetes Y/N Type _____ Date of diagnosis _____
Allergies Y/N Allergic to what? _____ What happens? _____
Medication allergy Y/N What happens? _____ Headaches Y/N
Other health problems _____
Current medication(s)/pills _____
Have you had any operations? Y/N Kind? _____ When? _____
Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substance(s)? _____
Name of family doctor _____ Date of last visit _____
Presently pregnant Y/N

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 _____
Other eye condition(s) Y/N What kind? _____ Relation _____

PERSONAL EYE INFORMATION

Have you had any eye operations or injuries? Y/N Type _____ Date _____
Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Spots/Flashes? Y/N
Date of last eye exam: _____ Date of most recent glasses: _____ Contacts? Y/N Type _____
Are you interested in laser vision correction? Y/N _____
Please list hobbies and sports _____

We request payment for services on the day that services are rendered. Your prompt payment helps keep our costs down and our fees low. We participate in many vision insurance plans and would be gl to help process your claim if we are a participating provider. Please remember that we are billing you insurance as a courtesy and any amounts not covered by your insurance and the deductibles are your responsibility. For your convenience we accept Visa, MasterCard and Discover credit cards.

Name of Vision Insurance Plan: _____ Please Sign _____

Thank You!