

Patient History Questionnaire



(Circle) Dr. Mr. Mrs. Miss

Name: _____ Date: _____
(First) (M.I.) (Last)

*if patient is a minor, name(s) of parent(s): _____ Date of Birth: ___ / ___ / ___ Age: _____

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

Phone (h): (_____) _____ Phone (w): (_____) _____ Phone (c): (_____) _____

Employer/Occupation: _____

How did you find us? _____

E-mail: _____ Please check if you do NOT wish to receive eye care updates

Payment is due at the time of service. Payment will be made via: cash check credit card
 insurance _____
(Type)

PATIENT MEDICAL INFORMATION

Do you currently, or have you had, any problems in the following areas? (✓) all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> cardiovascular/heart disease | <input type="checkbox"/> cancer | <input type="checkbox"/> headache |
| <input type="checkbox"/> respiratory | <input type="checkbox"/> endocrine/glands | <input type="checkbox"/> nervous system |
| <input type="checkbox"/> blood/lymph | <input type="checkbox"/> thyroid | <input type="checkbox"/> psychiatric/psychological |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> gastrointestinal | <input type="checkbox"/> muscles/bones |
| <input type="checkbox"/> high cholesterol | <input type="checkbox"/> urinary tract | <input type="checkbox"/> integument/skin |
| <input type="checkbox"/> diabetes (date of diagnosis: _____) | <input type="checkbox"/> ears/nose/throat | <input type="checkbox"/> allergic/immunologic |

Please explain: _____

Other health problems: _____

Are you currently taking medication? y n Please list: _____

Are you allergic to medication? y n Please list: _____

FAMILY EYE & MEDICAL HISTORY

Please check (✓) any conditions that have occurred in your immediate family:

- | | | | |
|---|----------------|--|----------------|
| <input type="checkbox"/> glaucoma | relation _____ | <input type="checkbox"/> cataracts | relation _____ |
| <input type="checkbox"/> macular degeneration | relation _____ | <input type="checkbox"/> diabetes | relation _____ |
| <input type="checkbox"/> retinal detachment | relation _____ | <input type="checkbox"/> high blood pressure | relation _____ |

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PATIENT'S EYE HISTORY

Do you wear glasses? y n Do you wear contact lenses? y n soft/disposable hard/rigid gas permeable
Have you ever worn contact lenses? y n Are you interested in wearing contact lenses? y n possibly, tell me more
Are you planning to get new glasses today? y n maybe, depending on the exam

When was your last eye exam? _____

Check all that apply: itchy eyes stinging/burning red eyes eye strain/eye fatigue blurry vision flashes/floaters

Please check any of the following conditions you have/had:

glaucoma retinal detachment macular degeneration cataracts dry eyes

Do you have any other eye conditions or problems? If so, describe _____

Have you had LASIK? If so, when/where: _____

Have you had a serious eye injury? If so, describe: _____

Are you using any eye drops (prescription or over-the-counter)? Please list: _____

Please describe any problems with your eyes for which you are seeking treatment today: _____

Is there any physician you would like to have today's exam results sent to? _____
(Name)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I authorize the release of medical information regarding myself/my dependents and my current condition to my referring, consulting, or treating physicians.

Signature of Patient/guardian: _____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT:

We keep a record of the health care services we provide to you. This Notice is available at your request. Your health information will be used only to treat you. We will not disclose your records to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. We will use your information to bill your insurance if necessary to receive payment for services or products. Our Notice of Privacy Practices is available at the reception desk. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information.

I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act (HIPPA).

Signature of Patient/guardian: _____

FOR DOCTOR'S USE ONLY: This form was reviewed by _____

date: _____