History Questionnaire

PERSONAL INFORMATION

Patient's Name _____Male ☐ Female ☐ Date of Visit _____

Address _____City _____ State _____ Zip _____

Date of Birth ____/ _____/ _____ Social Security # _____ Spouse/Parent _____

Occupation _____ Employer _____

Hobbies _____ Who may we thank for referring you?_____

CONTACT INFORMATION

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

What is the best way for us to reach you? Home ☐ Cell ☐ Work ☐ Email ☐

INSURANCE INFORMATION

Primary Care Physician: _____ Phone # _____

Vision Insurance Company _____ Member ID# _____

Name of Member _____ Member's SS# _____

Member's Date of Birth ____/ ____/ _____ Relationship to Patient _____

Health Insurance Company _____ Member ID# _____

Name of Member _____ Member's SS# _____

Member's Date of Birth ____/ ____/ _____ Relationship to Patient _____

Name of Employer: _____ Group # _____

Secondary Health Insurance (if applicable) _____Member ID# _____

TELL US ABOUT YOUR EYES

When was your last eye exam?_____

Do you wear glasses? Yes ☐ No ☐

Are you planning to purchase glasses today? Yes ☐ No ☐

Do you have problems with glare or reflections? Yes ☐ No ☐

Do you wear contacts? Yes ☐ No ☐

Do your eyes get dry at least once per day? Yes ☐ No ☐

Do you spend a lot of time outdoors? Yes ☐ No ☐

Are your eyes sensitive to sunlight? Yes ☐ No ☐

Do you work on a computer? Yes ☐ No ☐

How many hours per day? _____

Are you interested in Laser vision correction? Yes ☐ No ☐

What is the purpose for your visit today? _____

DO YOU HAVE ANY OF THESE EYE CONDITIONS?

Cataract	Yes ☐ No ☐	Macular Degeneration	Yes ☐ No ☐
Glaucoma	Yes ☐ No ☐	Retinal Detachment	Yes ☐ No ☐
Blindness	Yes ☐ No ☐	Turned/Lazy Eye	Yes ☐ No ☐
Eye injury	Yes ☐ No ☐	Flashes of Light	Yes ☐ No ☐
Eye surgery	Yes ☐ No ☐	Floaters/Spots	Yes ☐ No ☐
Redness	Yes ☐ No ☐	Watering	Yes ☐ No ☐
Double Vision	Yes ☐ No ☐	Itching	Yes ☐ No ☐
Keratoconus	Yes ☐ No ☐	Diabetic Retinopathy	Yes ☐ No ☐
Blurred vision	Yes ☐ No ☐	Crossed Eyes	Yes ☐ No ☐
Burning	Yes ☐ No ☐	Double Vision	Yes ☐ No ☐
Dryness	Yes ☐ No ☐	Eye Pain	Yes ☐ No ☐

Do any of your family members have any eye diseases? Yes ☐ No ☐

If yes: What condition? _____ Relation to you: _____

DO YOU HAVE ANY OF THESE MEDICAL CONDITIONS?

Heart	Yes ☐ No ☐	Respiratory/Asthma	Yes ☐ No ☐
Allergies	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Ear/Nose/Throat	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Blood/Lymph	Yes ☐ No ☐
Thyroid	Yes ☐ No ☐	Stomach/Colon	Yes ☐ No ☐
Headache	Yes ☐ No ☐	Mental Depression	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Genital/kidney/bladder	Yes ☐ No ☐
Hepatitis	Yes ☐ No ☐	HIV/AIDS	Yes ☐ No ☐

Do any of your family members have any medical conditions? Yes ☐ No ☐
If yes: What condition? _____ Relation to you: _____

List any prescription medications you are taking:

_____

_____

List any allergies to medication you have:

_____

_____

Do you use cigarettes/tobacco/alcohol/other substances? _____

Patient/Parent Signature _____ Date _____

Information Reviewed/Updated:

Date _____ Date _____ Date _____ Date _____

Initials _____ Initials _____ Initials _____ Initials _____

Doctor Signature _____ Date: _____