

TODAY'S DATE: _____

PATIENT HISTORY QUESTIONNAIRE

LAST NAME: _____ FIRST NAME: _____ M.I.: _____ SEX: M / F DATE OF BIRTH: ___/___/___

ADDRESS: _____ CITY/STATE/ZIP: _____ MARITAL STATUS: Single Married Divorced Widowed

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____ E-MAIL: _____

IF PATIENT IS A MINOR list name of PARENT/LEGAL GUARDIAN: _____ RELATIONSHIP TO PATIENT: _____

INSURED INFORMATION

INSURED NAME: _____ DATE OF BIRTH: ___/___/___ RELATIONSHIP TO PATIENT: _____ S.S.N.: ___/___/___

EMPLOYER: _____ OCCUPATION: _____ INSURANCE COMPANY: _____

SOCIAL/WORK HISTORY:

Do you smoke? YES / NO If yes, how much/long ? _____ Do you drink alcohol? YES / NO If yes, amount/ how long ? _____

Do you have visual difficulty when driving ? YES/NO How many hours a day do you use a computer? _____ Symptoms (if any): _____

Activities performed at work and/or recreation that you might want special glasses for: _____

EYE EXAM/EYEWEAR HISTORY:

DATE OF LAST EYE EXAM: _____ Were you dilated? YES / NO / NOT SURE

A Dilated Exam is recommended for everyone as it allows for a thorough evaluation of your eyes. Dilation is necessary for the early detection of many sight- threatening conditions. Dilating drops enlarge your pupils, increase your sensitivity to light and blur your near vision. These effects could last up to 8 hours.

Do you have a current pair of glasses ? YES/ NO If YES, how old is your present pair of glasses? _____

Are you interested in getting contacts ? YES / NO

If you currently wear contacts, what type of contact lenses do you wear : Circle your answer: RGP/Hard Soft Disposables

How old is your present pair of contact lenses? _____

Yearly Contact Lens Evaluations are necessary for the doctor to determine the health of your cornea and issue a contact lens prescription. Contact Evaluations are an additional fee. Do you want a contact lens evaluation? ** YES / NO **I understand that there is an additional fee for this service : Initials _____

MEDICAL INFORMATION:

Name of PCP: _____ Phone Number : _____ Date of last medical exam: _____ What is your general health? _____

Are you currently Pregnant or Nursing? _____ Current medication(s): _____

Allergies to Medication :Yes / No Please list Medication and Reaction _____

Operations	Type	Date
_____	_____	_____

PERSONAL AND FAMILY HISTORY:

(I am adopted or unaware of this information)

Diagnosed with	SELF	FAMILY RELATIONSHIP	Diagnosed with	SELF	FAMILY RELATIONSHIP
Asthma/ Respiratory Disease	___	___	Heart Disease	___	___
Arthritis	___	___	High Blood Pressure	___	___
Blindness	___	___	Kidney Disease/ Stones	___	___
Cancer	___	___	Lazy Eye/ Amblyopia	___	___
Cataract	___	___	Lupus/ other Auto-Immune	___	___
Color 'Blind'	___	___	Lung Disease	___	___
Depression/ Anxiety	___	___	Migraines/ Headaches	___	___
Diabetes Type: _____	___	___	Retinal Detachment/ Disease	___	___
Double Vision	___	___	Seizures/ Head Trauma	___	___
Dry Eye Syndrome	___	___	Thyroid Disease	___	___
Eye Injury	___	___	Turned Eye	___	___
Eye Surgery	___	___	Other Eye Condition	___	___
Glaucoma	___	___	Other	___	___

Have you been exposed to or infected with: gonorrhea hepatitis HIV syphilis

GLASSES/CONTACT LENS EXPIRATION DATE: I understand that all glasses and contact lens prescriptions expire ONE YEAR from the examination. I understand that expiration dates apply in order to help protect my eye health. Initial _____

CONTACT LENS WEARER: I understand that contact lenses are a medical device regulated by the US Food and Drug Administration. Like any medical device, proper care is necessary. I understand the necessity of follow-up care and an annual contact lens evaluation to monitor my eye health. I understand that use of this medical device presents risk of possible infection and other complications. I also understand that if I am being fitted for contact lenses, all follow-up appointments must be attended to within the first THREE MONTHS from my original exam. After the first THREE MONTHS, office visit charges may apply. Initial _____

HIPPA ACKNOWLEDGMENT:

I _____ acknowledge that I received a copy of the NOTICE OF PRIVACY PRACTICES (HIPPA).

Signature _____ Date _____

PATIENT REVIEWED: CHANGES MADE _____ NO CHANGES _____ CHANGES MADE _____ NO CHANGES _____

Doctor Use Only: Reviewed by _____ No changes Date _____ Reviewed by _____ No changes Date _____