PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

I have read/received a copy of Dr.Caroline Griego's NOTICE OF PRIVACY PRACTICES (HIPPA) _____ _____

By initializing and dating below I acknowledge that I have reviewed & made the necessary changes to my HISTORY QUESTIONSIRE. The information is correct and current.
TODAYS DATE: _____

LAST NAME: _____ FIRST NAME:_____ MI: _____
ADDRESS: _____ CITY: _____STATE:_____ ZIP _____
BEST NUMBER TO REACH YOU AT:_____ MARITAL STATUS: Single Married Divorced Widowed
SEX: M / F DATE OF BIRTH: _____/_____/_____ S.S.N: _XXX_/__XX___/_____ (LAST 4 ONLY)
EMPLOYER: _____ OCCUPATION: _____ WORK PHONE: _____
EMERGANCY CONTACT NAME: _____ RELATIONSHIP: _____PHONE NUMBER: _____

HOW DID YOU HEAR ABOUT THE OFFICE? _____

GRANTOR INFORMATION circle one (self, spouse, parent/guardian)

LAST NAME: _____ FIRST NAME:_____ MI: _____
ADDRESS: _____ CITY: _____STATE:_____ ZIP _____
SEX: M / F DATE OF BIRTH: _____/_____/_____ S.S.N: _XXX_/__XX___/_____ (LAST 4 ONLY)
EMPLOYER: _____ WORK PHONE: _____
INSURANCE COMPANY: _____ MEMBER ID: _____

OCULAR HEALTH HISTORY

DATE OF LAST EYE EXAM: _____ WERE YOU DILATED? YES / NO
DO YOU WEAR GLASSES? YES / NO IF YES, APPROXIMATELY HOW OLD IS YOUR CURRENT PAIR?_____
DO YOU WEAR CONTACT LENSES? YES / NO IF YES, WHAT TYPE OF CONTACT LENSES YOU CURRNETLY WEAR?
Circle one: Gas Permeable (RGP) or Disposable: Brand if known _____

CONTACT LENS WEARERS must have a Yearly Contact Lens Evaluation and possibly follow-up care to receive a prescription for contact lenses. First time wearers will also need Contact Lens Training. There are additional fees for these services. (circle one) I WANT I DO NOT WANT a prescription for contact lenses

Do you have any *eye* conditions or problems? Yes / No If yes, what kind?_____
Have you had any *eye* operations? Yes / No Type/Date: _____
Have you had an *eye* injury? Yes / No Kind/Date: _____
Do *you* have: Glaucoma: Yes / No Cataracts: Yes / No Dry eyes: Yes / No Macular degeneration: Yes / No
Retinal detachment? Yes / No Blurred vision (with correction)? Yes / No
Additional information _____

PERSONAL MEDICAL HISTORY

PRIMARY CARE PHYSICIAN: _____ PHONE NUMBER:_____
Date of last visit _____ How is your general health? _____
Have you had any operations? Yes / No KIND / DATE? _____
Allergies to medication? Yes / No Which and Reaction: _____
Current medication(s)_____

DO YOU TAKE ANY MEDICATIONS FOR THE FOLLOWING CONDITIONS? Gastrointestinal: Yes / No Nervous: Yes / No
Endocrine (glands): Yes / No Ears/Nose/Throat: Yes / No Urinary: Yes / No Blood/Lymph: Yes / No
Cardiovascular: Yes / No Muscles/Bones: Yes / No Allergic/Immunologic: Yes / No Respiratory: Yes / No
Integumentary (skin): Yes / No Headaches: Yes / No High blood pressure: Yes / No Eyes: Yes / No Mental: Yes / No
Diabetes: Yes / No If yes what Type _____ Is your Blood Sugar under control? Yes / No
Other health problems _____
FEMALES ONLY: Are you Pregnant or Nursing? Yes / No If pregnant, how many weeks along are you? _____

FAMILY MEDICAL HISTORY

High blood pressure: Yes / No Relation _____ Macular degeneration: Yes / No Relation _____
Diabetes: Yes / No Type and Relation _____ Retinal detachment: Yes / No Relation _____
Glaucoma: Yes / No Relation _____ Cataracts: Yes / No Relation _____

DOCTOR USE ONLY:

REVIEWED BY: _____ ☐ No changes DATE _____ REVIEWED BY: _____ ☐ No changes DATE _____
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IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

CONTACT LENS SERVICE FEES

- Contact Lens Evaluations are a necessary service for all patients that want to wear or continue wearing contact lenses. This is NOT a component of a Comprehensive Eye Health Exam; CONTACT LENS EVUALATIONS are an additional service and have an additional fee associated with this service. The fee for this service is _____.

- To keep the cost down, we do not include Contact Lens Follow-up care in the Contact Lens Evaluation fee.. We only charge for this service when needed. Follow-up visit care is within the first 3 months from the date of exam. Dr Griego will let you know if she needs to see you for follow-up care. The fee for this service is _____.

- Examples for the need of follow-up visits are:

    - 1st time contact lens wearers
    - New patients to the office (even though you currently wear contact lenses)
    - Brand change
    - Power change
    - Comfort/reaction to lens material
    - Etc

- For the first time wearer, or changing from soft to RGP contact lens you will need a Contact Lens Training. The fee for this service is _____

- This training consists of:
    - Inserting and Removal of contact lens.
    - Proper lens handling
    - Cleaning and caring for your contact lenses
    - Wearing schedule
    - Etc

I have read and understood the above Contact Lens Service Fees. If I choose not to have this service(s) I am aware I will not be provided with a contact lens prescription and will not be able to order contact lenses.

_____ _____

I WANT THIS SERVICE I DO NOT WANT THIS SERVICE

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