PATIENT HISTORY QUESTIONNAIRE

MUST BE UPDATED AT EACH VISIT

PLEASE FILL IN ALL BLANKS. WRITE N/A IF QUESTION DOES NOT APPLY.

Date______________________ **PATIENT INFORMATION** SS# ______________________

PATIENT INFORMATION

Last Name ______________________ First Name ______________________ MI __________

Address ____

City ______________________ State __________ Zip__________

Telephone (W)______________ (H) ______________ Date of Birth __________ Age______

Occupation ______________________ Employer ______________________

Emergency contact name and phone #______________________________

Date of last eye exam ______________ Dilated? Y/N Email address:______________

Who is responsible for account? ______________________ Relationship ______________

MEDICAL INFORMATION PART I

What is your general health?____

Do you have problems with any of these systems?

Eyes: Y/N	Gastrointestinal: Y/N	Nervous: Y/N	Mental: Y/N
Ears/Nose/Throat: Y/N	Genitourinary: Y/N	Endocrine (glands): Y/N	AIDS/HIV: Y/N
Cardiovascular: Y/N	Musculoskeletal: Y/N	Blood/lymph: Y/N	Hepatitis: Y/N
Respiratory: Y/N	Skin: Y/N	Allergic/Immunologic: Y/N	

If YES to any questions above, please explain:______________________________

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____

MEDICAL INFORMATION PART II

Diabetes? Y/N Type ______ Date Diagnosed ________ Last Sugar Reading _______ When? ______________

Highest Sugar Reading ______________ Lowest ______________ Average________

Diabetes in Eyes? Y/N Retinal Laser Surgery? Y/N When?______________

Allergies? Y/N Allergic to what? ______________________ What happens?______________

Medication allergy? Y/N What happens? ______________________________

Headaches? Y/N

Other Health Problems ____

INSURANCE INFORMATION

Name of Insured ______________________ Relationship to Patient______________

Birthdate______________ Social Security #______________ Date Employed______________

Name of Employer ______________________ Work Phone #______________

Address ______________________ City______________ State________ Zip________

Insurance Co. ______________________ Group #______________ Employer #______________

Insurance Co. Address ______________________ City______________ State________ Zip________

How much is your deductible? ________ How much have you used?________ Max. annual benefit____________

PAYMENT IN FULL IS DUE AT TIME SERVICES ARE RENDERED

PATIENT / GUARANTOR LIABLE FOR ALL LEGAL AND COLLECTION FEES

OVER PLEASE →

MEDICATIONS (taken now or in past 6 weeks)

1. ______________________ used for? ______________________
2. ______________________ used for? ______________________
3. ______________________ used for? ______________________
4. ______________________ used for? ______________________
5. ______________________ used for? ______________________
6. ______________________ used for? ______________________

GENERAL INFORMATION

Have you had any operation(s)? Y/N Kind? ______________________ When? ______________

Do you use cigarettes/tobacco? __________ Alcohol? __________ Other Drugs/Substances? __________

Marital Status ______________________ Number of Children ______________

Name of Family Doctor ______________________ Date of Last Visit ______________

Date of Last Tetanus Shot ______________________

Pregnant? Y/N/NA If yes, __________ Months Presently Nursing? 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 operation(s)? Y/N Type ______________________ Date ______________

Have you had any eye injuries? Y/N Kind ______________________ Date ______________

Do you have glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Blurry Vision? Y/N

High eye pressures? Y/N Other eye problems? Y/N What Kind? ______________________

Do you wear glasses? Y/N Contact Lenses? Y/N Type/Brand __________ Power ________ Curve ________

Additional Information ______________________

Whom may we thank for referring you? ______________________

Doctor's Initials __________

INSURANCE ASSIGNMENT AND RELEASE

I, ______________________ hereby authorize all my (or my dependent's) appropriate insurance benefits be paid directly to Dr. ______________________ for products and/or services rendered. I understand that I am financially responsible for uncovered services and that I will make prompt payment for any services not paid or covered by my insurance company. I also authorize the above named physician to release any information required to process this claim. I also understand that verification of insurance coverage is not a guarantee of payment and that I am responsible for all unpaid charges. **I ALSO UNDERSTAND THAT I AM LIABLE FOR ALL LEGAL AND COLLECTION FEES.**

______________________ ______________

Responsible Party Signature Date

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Relationship to Patient