Patient Questionnaire

Demographic Information

_____

Last First MI Nickname

_____

Mailing Address City State Zip code

_____ _____

Date of Birth Social Security Number

Contact Information

List any numbers or addresses that we may contact you by:

Home _____

Work _____

Cell _____

Email _____

Phone Preference:

☐ Home ☐ Work ☐ Cell

May we leave a voicemail or send a text message?

☐ Yes, to all phone numbers

Or select from the following:

☐ Home ☐ Work ☐ Cell

Other Demographic Information

Marital Status: ☐ Single ☐ Married ☐ Other

Employment and Occupation

To better identify your visual needs, please let us know what kind of work you do:

Occupation _____

Employer _____

If student, what grade? _____

Referral Information

Who may we thank for referring you to us?

☐ Family/Friend _____

☐ Provider _____

☐ Other: ☐ Dex ☐ Facebook ☐ Newspaper

☐ Radio ☐ Walk in ☐ Website

☐ Other:_____

Primary Insurance Information

Company Name_____

Type: ☐ Medical ☐ Vision ☐ Medical & Vision

Secondary Insurance Information

Company Name_____

Type: ☐ Medical ☐ Vision ☐ Medical & Vision

Patient or Guardian Signature

X_____ _____ _____

Patient or Guardian Signature Date If Guardian, Print Name

Patient History

Patient Reason of Visit

What is the reason for your visit today?

When was your last eye exam?

Eye Conditions

Y / N Cataract
Y / N Age-related Macular Degeneration
Y / N Glaucoma
Y / N Diabetes
Y / N Dry Eye
Y / N Eye infection, inflammation, or allergy
Y / N Floaters and/or flashes of light
Y / N Iritis or Uveitis
Y / N Retina defects or degenerations
Other Conditions:

Vision Correction

Do you wear glasses? Yes / No

Do you wear contacts? Hard / Soft / No
If yes, what brand of contacts do you use? _____

Review of Systems

Have you had problems with or treating any of the following?
If yes, please describe.

Whole System/Constitution Y / N _____
☐ Cancer ☐ Developmental Disabilities
Ears/Nose/Throat Y / N _____
Neurological Y / N _____
Psychiatric Y / N _____
Cardiovascular Y / N _____
Respiratory Y / N _____
Gastrointestinal Y / N _____
Genitourinary Y / N _____
Musculoskeletal Y / N _____
Skin (Integumentary) Y / N _____
Glands (Endocrine) Y / N _____
Diabetes Mellitus: ☐ Type 1 ☐ Type 2 ☐ Gestational
Hematologic/Lymphatic Y / N _____
Allergic/Immunologic Y / N _____
Are you pregnant? Y / N

Pharmacy and Provider

What pharmacy do you use?_____
At what pharmacy location? _____
Who is your primary care provider? _____

Medications

Do you take prescription medications? Y / N
Did you bring a list? Y / N
If yes, please give to the front desk to copy.
If no, please list your medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Non-prescription Medications:

_____ _____
_____ _____

Allergies

Medical Allergies/Type of Reaction:
Other Allergies/Type of Reaction:
☐ No known allergies

Social History

Do you use any of the following?

Alcohol Y / N
Amount and frequency _____

Tobacco Y / N
Type? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless Tobacco
Amount _____

Family Medical History

Have any immediate family members had any of the following conditions? If so, what is their relation to you?

Y / N Cancer _____
Y / N Diabetes type 1 _____
Y / N Diabetes type 2 _____
Y / N High blood pressure _____
Y / N Hyperthyroidism _____
Y / N Hypothyroidism _____
Other Medical Conditions:

Family Ocular History

Have any immediate family members had any of the following conditions? If so, what is their relation to you?

Y / N Cataract _____
Y / N Macular Degeneration _____
Y / N Glaucoma _____
Other Eye Conditions: _____