PATIENT QUESTIONAIRE

Name of person who assisted patient with this form, if any: _____
Relation: _____

Name: _____ **DOB**: _____/____ /____ **Social Security#**: _____ **Date**:_____
Name you would prefer to be called in this office: _____ Married __ Single __ Widowed __ Divorced __ Sex: M / F
Preferred lang.: Eng /Spanish Ethnicity : American Indian /Alaska Native /Asian /African American /Native Hawaiian /Hispanic /White

Were you **referred** to our office? **( )** Yes **( )** No If yes, whom may we thank for this referral? _____
How would you like to be contacted?: Phone / mail / email: _____ Is Text OK? Y / N
Address: _____ City/State/Zip: _____
Home Phone: _____ Cell phone: _____ email: _____
Occupation: _____ **Employer**: _____
Business address: _____ Bus. Phone: _____
Primary Care Physician: _____ Address: _____ Phone:_____
Insurance: _____ Name of Insured: _____ DOB:_____
Insurance ID#: _____ Insured Social Security Number:_____
Spouse: _____ Employer: _____
Nearest adult relative/Emergency contact Name: _____ Phone:_____
Financially Responsible Party: _____
Describe the main reason for your visit today: _____
Have you ever been treated for this problem? Y/N When was your last eye exam? _____ Name of Doctor: _____
Age of present glasses: _____ Age of present Contact lenses: _____ Type: soft / rigid/extended wear. Are they comfortable?: Y/N
Has any family member been here before? Y/N Name & Relationship: _____

Medical History:

Are you generally healthy? Y/ N If no please describe (include onset):_____
_____
Please circle any of the following that you have had: eye turn amblyopia/lazy eye drooping eyelid glaucoma
retinal disease cataracts eye infections eye injury Have you had cataract surgery: Y/N
Please describe any visual symptoms: _____
Please list all major injuries, surgeries, and hospitalizations you have had (include year): _____
_____
Please list **ANY** prescription and OTC medications you are currently taking: _____
_____
Medication allergies: _____ Reaction: _____ Onset: _____
Non-Medication allergies: _____ Reaction: _____ Onset: _____
Height: _____ Weight: _____ Are you pregnant or nursing? Y / N

Family History:

			Relation:	Mom's side	Dad's side				Relation:	Mom's side	Dad's side
History Unknown	Y					Cancer, type:_____	Y	N	_____	_____	_____
Blindness	Y	N	_____	_____	_____	Diabetes	Y	N	_____	_____	_____
Cataract	Y	N	_____	_____	_____	Heart Disease	Y	N	_____	_____	_____
Eye turns	Y	N	_____	_____	_____	High Blood pressure	Y	N	_____	_____	_____
Glaucoma	Y	N	_____	_____	_____	Kidney disease	Y	N	_____	_____	_____
Macular degeneration	Y	N	_____	_____	_____	Thyroid disease	Y	N	_____	_____	_____
Retinal detachment	Y	N	_____	_____	_____	Other: _____	Y	N	_____	_____	_____

Social History:

Do you smoke?: Never Former Current When did you stop smoking? _____ months / years ago. Smokeless tobacco? Y/N Marijuana? Y/N
Alcohol use: None / Daily / Social use / Alcohol dependence
Do you use any illegal drugs?: Y/N
Do you drive? Y/N Do you have any visual difficulty when driving? _____

OVER →

Cardiovascular/Vascular:			Onset
High Blood Pressure	Y	N	_____
Heart Probl.: _____	Y	N	_____
Vascular Disease	Y	N	_____
Other: _____	Y	N	_____
Constitutional:			
Fever	Y	N	_____
Weight gain/loss	Y	N	_____
Fatigue:	Y	N	_____
Other: _____	Y	N	_____
Endocrine:			
Diabetes	Y	N	_____
Thyroid	Y	N	_____
Pituitary disorder	Y	N	_____
Other:_____	Y	N	_____
Gastrointestinal:			
Diarrhea	Y	N	_____
Constipation	Y	N	_____
Other:_____	Y	N	_____
Genitourinary:			
Genital	Y	N	_____
Kidney	Y	N	_____
Bladder	Y	N	_____
Other: _____	Y	N	_____
Ears/Nose/Mouth/Throat:			
Runny nose	Y	N	_____
Chronic cough	Y	N	_____
Dry throat/mouth	Y	N	_____
Hearing loss	Y	N	_____
Sinus disease	Y	N	_____
Other: _____	Y	N	_____
Hematologic/Lymphatic			
Anemia	Y	N	_____
Blood disorder	Y	N	_____
Bleeding problem	Y	N	_____
Other: _____	Y	N	_____

Immune system/Infections:			Onset
Sjogrens syndrome	Y	N	_____
Autoimmune disease	Y	N	_____
HIV Positive/AIDS	Y	N	_____
Lyme disease	Y	N	_____
Sarcoidosis	Y	N	_____
Tuberculosis	Y	N	_____
Other: _____	Y	N	_____
Integumentary/Skin:			
Skin rash/hives	Y	N	_____
Dermatitis	Y	N	_____
Dry skin	Y	N	_____
Other: _____	Y	N	_____
Musculoskeletal:			
Arthritis	Y	N	_____
Muscle pain	Y	N	_____
Skeletal Disorder	Y	N	_____
Other: _____	Y	N	_____
Neurological:			
Headache/Migraine	Y	N	_____
Brain tumor	Y	N	_____
Seizures	Y	N	_____
Stroke	Y	N	_____
Other: _____	Y	N	_____
Psychiatric: (Please describe)	Y	N	
_____	Y	N	_____
_____	Y	N	_____
Respiratory:			
Asthma	Y	N	_____
Emphysema	Y	N	_____
Chronic bronchitis	Y	N	_____
Other: _____	Y	N	_____

(Person who is filling this form out, please sign below. If you are not the patient please indicate as such. Thank you)
Signed:_____ Print Name:_____Relation: _____ Date:_____