



Today's Date: _____

Patient Information Questionnaire

Patient Name: _____ **Name Preferred:** _____
LAST FIRST MI

Mailing Address: _____
STREET CITY STATE ZIP

Home Phone#: _____ **Work Phone#:** _____

Cell Phone#: _____ **Email Address:** _____

Date of Birth: _____ **Social Security #** _____

Marital Status (circle): Single Married Widowed Domestic Partner

Employer: _____ **(circle):** FT PT FTStudent PTStudent Retired

Occupation: _____ **Sex (circle):** M F

Emergency Contact: _____ **Phone#:** _____

How did you first hear about us?

(Circle) Sign Insurance Directory Flyer Postcard Radio Friend/Family, who? _____

Patient Eye History

Reason for your visit today: _____

- | | |
|---|---|
| <input type="checkbox"/> Blurry at distance | <input type="checkbox"/> Blurry at near |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Flashes of Light |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Redness |

Previous Eye Doctor: _____

Date of Last Eye Exam: _____

Any special vision needs?

- Interested in trying Contact Lenses
- Interested in learning more about Lasik
- Need work related glasses – safety, computer, etc.
- Need recreational glasses – golf, fishing, etc.

Have YOU been diagnosed or have experienced:

- | | |
|---|--|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Lazy Eye/Amblyopia | <input type="checkbox"/> Eye Turn/Strabismus |
| <input type="checkbox"/> Color Deficiency | <input type="checkbox"/> Loss of Vision |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Dry Eye |
| <input type="checkbox"/> Iritis/Uveitis | <input type="checkbox"/> Ocular Herpes |

Retinal Disease _____

Corneal Problems _____

Other _____

Eye Surgeries: _____ Date _____

Eye Injuries: _____ Date _____

Current Eye Drop Prescriptions, over the counter eye drops or vitamins used: _____

Patient Medical History

Primary Care Physician _____

Phone Number _____

Have YOU ever been diagnosed with or had problems with any of these systems?

- | | |
|--|---|
| <input type="checkbox"/> Diabetes Type _____ When diagnosed? _____ | |
| <input type="checkbox"/> High Blood Pressure When diagnosed? _____ | |
| <input type="checkbox"/> Cancer What type? _____ | |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Ear/Nose/Throat | <input type="checkbox"/> Gastrointestinal |
| <input type="checkbox"/> Endocrine (Glands) | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Muscle/Bone |
| <input type="checkbox"/> Blood/Lymphatic | <input type="checkbox"/> Immunological |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Depression/Psychiatric | <input type="checkbox"/> Cholesterol |

Other Issues Not Listed Above _____

Are You Currently...

- | | |
|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> A Smoker | |

Current Medications: _____

Major Surgeries _____

Allergy to Medications _____

Other Allergies _____

Family Medical/Eye History

- | | Who? | Which Side? |
|---|-------|-------------|
| <input type="checkbox"/> Heart Disease | _____ | _____ |
| <input type="checkbox"/> Diabetes | _____ | _____ |
| <input type="checkbox"/> Cancer (Type) _____ | _____ | _____ |
| <input type="checkbox"/> Blindness | _____ | _____ |
| <input type="checkbox"/> Cataracts | _____ | _____ |
| <input type="checkbox"/> Glaucoma | _____ | _____ |
| <input type="checkbox"/> Corneal Problems | _____ | _____ |
| <input type="checkbox"/> Lazy/Turned Eye | _____ | _____ |
| <input type="checkbox"/> Macular Degeneration | _____ | _____ |
| <input type="checkbox"/> Retinal Disease | _____ | _____ |