Patient History Questionnaire

(Please Print and Fill Out Completely)
MUST BE UPDATED AT EACH VISIT

1. MS., MRS. MR. ______ DATE ______
2. ADDRESS ______ CITY ______
3. STATE ______ ZIP ______ E-MAIL ADDRESS ______
4. HOME PHONE ______ / WORK PHONE ______
5. BIRTHDATE ______ SOC. SEC. # ______
6. PARENT OR GUARDIAN ______ SPOUSE ______
7. EMPLOYER ______ OCCUPATION ______
8. EYE CARE INSURANCE ______ SPOUSE'S S.S. # ______
9. SPOUSE'S EYE CARE INSURANCE ______
10. HOBBY / SPORTS / OTHER ______
11. WHOM MAY WE THANK FOR REFERRING YOU? ______ Ad? ______ Yellow Pages? ______ Insurance Plan? ______
12. DO YOU WEAR GLASSES? ☐ YES ☐ NO
13. DO YOU WEAR CONTACT LENSES? ☐ YES ☐ NO DO YOU WANT CONTACTS? ☐ YES ☐ NO COLORED? ☐ YES ☐ NO
14. IF YOU WORK ON A COMPUTER, HOW MANY HOURS A DAY? ______
15. WHAT TYPE OF MEDICAL INS. DO YOU HAVE? ______ PRIMARY CARE PHYSICIAN ______
16. ARE YOU INTERESTED IN THE LASER PROCEDURE TO CORRECT VISION IF POSSIBLE? ☐ YES ☐ NO
17. ARE YOU PREGNANT? ☐ YES ☐ NO ☐ MAYBE

18. METHOD OF PAYMENT: ☐ CASH ☐ CHECK ☐ CREDIT CARD

PERSONAL EYE INFORMATION

☐ NO ☐ YES Have you had any eye operations? Type ______ Date ______
☐ NO ☐ YES Have you had an eye injury? ______ Date ______
☐ NO ☐ YES Do you have glaucoma? ☐ NO ☐ YES Cataracts? ☐ NO ☐ YES Dry eyes? ☐ NO ☐ YES Blurred vision?

REVIEW OF SYSTEMS: IF YES, PLEASE CIRCLE CONDITION.

☐ NO ☐ YES Constitutional Symptoms: Fever Weight Loss ______
☐ NO ☐ YES Eyes: Cataract Glaucoma Macular Degeneration Lazy Eye ______
☐ NO ☐ YES Ears, Nose, Mouth, Throat: Hearing Loss Sinus Disease ______
☐ NO ☐ YES Cardiovascular: Angina Heart Attack Surgery Heart Failure ______
☐ NO ☐ YES Blood Pressure Treatment: Diet Medication Closely Monitored ______
☐ NO ☐ YES Respiratory: Asthma Emphysema Bronchitis ______
☐ NO ☐ YES Gastro: Ulcer Hernia ______
☐ NO ☐ YES Genitourinary: Kidney Prostate Bladder ______
☐ NO ☐ YES Mus/Skel: Rheumatoid Arthritis Osteoarthritis ______
☐ NO ☐ YES Neuro: Numbness History Of Stroke Neurological Disease ______
☐ NO ☐ YES Psych: Depression, etc. ______
☐ NO ☐ YES Diabetes: Type ______ Date of Diagnosis ______
☐ NO ☐ YES Endo: Thyroid Disease ______
☐ NO ☐ YES Hem/Lymph: Bleeding Lumps/Masses ______
☐ NO ☐ YES Allergies: Allergic to what? ______ What happens? ______
☐ NO ☐ YES Medication Allergy: What happens? ______ Headaches ☐ NO ☐ YES
☐ NO ☐ YES Have you / are you being treated for Syphilis, Gonorrhea or HIV/AIDS? ______
☐ NO ☐ YES Please list medications you are currently taking: ______
☐ NO ☐ YES Do you use cigarettes / tobacco? ______ Alcohol? ______ Other substance(s)? ______
☐ NO ☐ YES Other Health Problems: ______

FAMILY HISTORY - *Answer to the best of your ability.*

☐ NO ☐ YES High blood pressure - Relation ______
☐ NO ☐ YES Diabetes - Relation ______
☐ NO ☐ YES Glaucoma - Relation ______
☐ NO ☐ YES Macular degeneration - Relation ______
☐ NO ☐ YES Retinal detachment - Relation ______
☐ NO ☐ YES Cataracts - Relation ______
☐ NO ☐ YES Other eye condition(s) - Relation ______

Doctor's Initials ______