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?_____

*Email address may be used for communication with you along with occasional office news and promotions

## Patient Eye History

Reason for your visit today:_____

_____

_____

❑ Blurry at distance ❑ Blurry at near
❑ Floaters ❑ Flashes of Light
❑ Dryness ❑ 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:*

❑ Glaucoma ❑ Cataracts
❑ Lazy Eye/Amblyopia ❑ Eye Turn/Strabismus
❑ Color Deficiency ❑ Loss of Vision
❑ Macular Degeneration ❑ Dry Eye
❑ Iritis/Uveitis ❑ 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?*

❑ Diabetes Type _____ When diagnosed? _____
❑ High Blood Pressure When diagnosed? _____
❑ Cancer What type?_____
❑ Migraine Headaches ❑ Thyroid
❑ Ear/Nose/Throat ❑ Gastrointestinal
❑ Endocrine (Glands) ❑ Skin
❑ Cardiovascular ❑ Muscle/Bone
❑ Blood/Lymphatic ❑ Immunological
❑ Respiratory ❑ Neurological
❑ Depression/Psychiatric ❑ Cholesterol

Other Issues Not Listed Above_____

_____

*Are You Currently…*

❑ Pregnant ❑ Nursing
❑ A Smoker

Current Medications: _____

_____

_____

_____

Major Surgeries_____

❑**Allergy to Medications** _____
Other Allergies_____

## Family Medical/Eye History

| | Who? | Which Side? |
|---|---|---|
| ❑ Heart Disease | | |
| ❑ Diabetes | | |
| ❑ Cancer (Type)_____ | | |
| ❑ Blindness | | |
| ❑ Cataracts | | |
| ❑ Glaucoma | | |
| ❑ Corneal Problems | | |
| ❑ Lazy/Turned Eye | | |
| ❑ Macular Degeneration | | |
| ❑ Retinal Disease | | |