Patient History Questionnaire

Last name_____ First name_____ MI_____

Address_____ City_____ Zip_____

Telephone (H)_____(W)_____

SSN_____-_____-_____Date of birth_____

Occupation_____Employer_____

Emergency contact_____ Telephone number_____

Date of last eye exam_____ Dilated? _____ Today's Date_____

Medical Information

What is your general health?_____

Do you have problems with any of these systems? (Please circle all that apply) Eyes Y/N

Gastrointestinal Y/N Nervous Y/N Mental Y/N Skin Y/N

Ears/nose/throat Y/N Genitourinary Y/N Endocrine Y/N Respiratory Y/N

Cardiovascular Y/N Blood/lymph Y/N Allergic Y/N Musculoskeletal Y/N

Please explain _____

Please answer all that apply:

Diabetes Y/N Type_____ Date of first diagnosis_____ Well controlled? Y/N

Allergies Y/N Allergic to what?_____ What happens?_____

Medication allergy Y/N What drug_____ What happens?_____

Other health problems_____

Current medication(s)_____

Have you had any operations? Y/N Kind_____ When?_____

Do you use cigarettes/tobacco? _____ Alcohol?_____ Other substances?_____

Name of family doctor_____ Telephone_____ Date of last visit_____

Date of last tetanus shot?_____ Do you have an Advance Directive for health care?_____ Are you Pregnant or Nursing?_____

Family History

High blood pressure Y/N Relation_____ Macular degeneration Y/N Relation_____

Diabetes Y/N Relation _____ Retinal detachment Y/N Relation_____

Glaucoma Y/N Relation_____ Cataract Y/N Relation_____

Other eye conditions Y/N What kind? _____ Relation_____

Personal Eye Information

Have you had an eye injury? Y/N Type_____ Eye infections? Type_____

Any eye operations? Y/N Type_____ Lazy eye? If so, which eye_____

Do you have glaucoma? Y/N Cataracts? Y/N Dry eye? Y/N Blurred vision? Y/N

Floaters? Y/N Any other Eye Problems? What kind?_____

Do you wear glasses? Y/N Contact lenses? Y/N Type_____

Additional information_____

Are you interested in Contact Lenses? Y/N Are you interested in Lasik? Y/N

Doctor's initials_____

Insurance Information (Please provide both vision and medical)

Vision Insurance:_____ I.D. No._____ Group No._____

Major Medical Ins:_____ I.D. No._____ Group No._____

Supplemental Ins._____ I.D. No._____ Group No._____

Employment Information of Insured

Employer:_____ **Address:**_____

Telephone:_____ **Contact Person**_____

Method of Payment: Please circle all that apply

Cash Check Charge Insurance

I,_____hereby assign all vision and/or medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance and any other health plans to William D. Marks O.D. and/or Southland Vision Care Inc.

This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payments of said benefits and services. This account is subject to a collection fee equal to 20% of the underlying balance in the event we are required to forward this account to a third party debt collector.

Signature_____Date_____

Patient reviewed on (date)_____ Patient initials_____ Doctor initials_____

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Patient reviewed on (date)_____ Patient initials_____ Doctor initials_____

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