# PATIENT HISTORY QUESTIONNAIRE (must be updated at each visit)

Last Name _____ First Name _____ MI ____ Age _____ ❒ Male ❒ Female

Address _____ City _____ State _____ Zip _____

Telephone (H) _____ (W) _____ S.S.# _____-_____-_____ DoB _____

Occupation _____ Employer _____ ❒ Single ❒ Married

Emergency Contact/Phone # _____ Name of Previous Dr. _____

Date of last eye exam _____ Dilated? _____ Referred By _____

How did you hear about our office? _____

Is anyone in your family an Eye Group patient? Y / N Who? _____

How many hours per day do you use a computer? _____ Hobbies _____

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Asthma | ❒ | ❒ | Head or spinal injuries | ❒ | ❒ |
| Kidney Disease | ❒ | ❒ | Seizures, fainting | ❒ | ❒ |
| Tuberculosis | ❒ | ❒ | Lupus | ❒ | ❒ |
| Diabetes | ❒ | ❒ | Temporal Arteritis | ❒ | ❒ |
| #of years | _____ | | HIV | ❒ | ❒ |
| Insulin | ❒ | ❒ | Cancer | ❒ | ❒ |
| # of years | _____ | | Sickle cell anemia | ❒ | ❒ |
| Migraines | ❒ | ❒ | High blood pressure | ❒ | ❒ |
| Depression | ❒ | ❒ | Stroke | ❒ | ❒ |
| Any nervous disorder | ❒ | ❒ | Are you pregnant | ❒ | ❒ |
| Heart Disease | ❒ | ❒ | Do you use tobacco | ❒ | ❒ |
| Ulcer | ❒ | ❒ | Do you use alcohol | ❒ | ❒ |
| Arthritis | ❒ | ❒ | or other substance | ❒ | ❒ |
| Hepatitis | ❒ | ❒ | Other health problems | ❒ | ❒ |

Please list all medications you are currently taking (including eye drops): _____

_____

List any medication you are allergic to: _____

What happens? _____

Surgical History: _____

Date of last tetanus shot: _____ Family Physician: _____

## PERSONAL EYE INFORMATION

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Cataracts | ❒ | ❒ | Cornea disease | ❒ | ❒ |
| Retina/macular disease | ❒ | ❒ | Glaucoma | ❒ | ❒ |
| Crossed eyes | ❒ | ❒ | Other eye disorders | ❒ | ❒ |

Do you wear: Eyeglasses? ❒ Yes ❒ No Contacts? ❒ Yes ❒ No

Are you interested in Contact Lenses? ❒ Yes ❒ No **LASIK?** ❒ Yes ❒ No

**Eye Surgery:** _____ Right _____ Left _____

**Eye Injuries:** _____

**Eye Problems:** _____

**FAMILY HISTORY: Has anyone in your family (blood relative) had any of the following in the past?**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Glaucoma | ❒ | ❒ | Retinal detachment | ❒ | ❒ |
| Cataracts | ❒ | ❒ | Diabetes | ❒ | ❒ |
| Cornea disease | ❒ | ❒ | Diabetic retinopathy | ❒ | ❒ |
| Macular/retina disease | ❒ | ❒ | Heart problems | ❒ | ❒ |
| Retinitis pigmentosa | ❒ | ❒ | Stroke | ❒ | ❒ |
| Other eye problems | ❒ | ❒ | Other health problems | ❒ | ❒ |

**CONSENT TO TREAT**

By signing this form, I consent to treatment for myself and/or on the behalf of the Minor for which this information pertains. I give my permission for the doctor(s) to examine, diagnose, and initiate treatment as deemed appropriate. I further attest that I am the Parent/Legal Guardian of the Minor and have the authority to authorize care or treatment. **SIGNATURE:** _____ **DATE:** _____

Vision Insurance Carrier _____

Insured Name _____ SS# _____ DoB _____ ❒ Male ❒ Female

While the Eye Group, P.C. is happy to file my insurance for me, I understand I am responsible for all charges should my claim be denied. **SIGNATURE:** _____

Tech Signature _____

Physician Signature _____ Date _____

**History Review**

**We recommend yearly eye examinations. Contact lens prescriptions expire after one year; eyeglass prescriptions after two years.**