PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Date: Patient E-mail:

Last Name__________ First Name__________ MI____ Marital Status S M D WID

Address__________ City__________ State_____ Zip__________

Home Phone__________ Work Phone __________ Cell Phone__________

Date of Birth__________ Occupation__________ Employer__________

Date of Last Exam (***if not done at this office***)__________ Exam done by Dr. __________

Responsible Party for Payment__________

PRIMARY VISION INS__________ **SECONDARY VISION INS** __________

PRIMARY MEDICAL INS__________ **SECONDARY MEDICAL INS** __________

Primary INS Holder Last 4 Digits of SS#__________ **Patient's Last 4 Digits of SS#**__________

Medical Information - Review of Systems

What is your general health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Do you have problems with any of the following?

Cardiovascular .... ☐ Yes ☐ No

Eyes (burn / itch) .... ☐ Yes ☐ No

Endocrine (glands) .... ☐ Yes ☐ No

Allergic / Immunologic .... ☐ Yes ☐ No

Respiratory .... ☐ Yes ☐ No

Do you smoke? .... ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No Type__________ Date of Diagnosis __________

CURRENT MEDICATIONS __________

Allergies to Medications: ☐ Yes ☐ No Which?__________

Reaction(s)?__________

Other Health Problems__________

NAME and **CITY** of Family Doctor__________

Personal Eye Information

Have you had any eye operations? ☐ Yes ☐ No Type__________ Date__________

Have you had an eye injury? ☐ Yes ☐ No Kind__________ Date__________

Retinal Detachments? ☐ Yes ☐ No Blurred Vision? ☐ Yes ☐ No

Do you wear Glasses? ☐ Yes ☐ No Contact Lenses? ☐ Yes ☐ No Brand__________

Additional Information__________

Who may we thank for referring you to our office?__________

Doctor Use Only

Reviewed by__________ ☐ No Changes Date__________

Reviewed by__________ ☐ No Changes Date__________

Reviewed by__________ ☐ No Changes Date__________

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PATIENT CONSENT FORM

Your privacy, including the confidentiality of your health information, is very important to us. Additionally, federal law prohibits the unauthorized release of your protected health information except as allowed for treatment, payment, or health care operations.

To protect your personal health information, our office has a Notice of Privacy Practices that provides information about how we may use and disclose your protected health information. You have the right to review the Notice of Privacy Practices before signing this consent form. The terms of our Notice of Privacy Practices may change. If we change our Notice, you may obtain a revised copy by calling our office.

You also have the right to request that we restrict how your protected health information can be used or disclosed for treatment, payment, or health care operations.

By signing this form, you have agreed to our use and disclosure of your protected health information under the guidelines set up for federal regulations. You may revoke your consent, in writing, at any time, except to the extent that we have already acted in reliance upon your consent as shown by your signature below.

Print Name **(Patient's)** ________________________________

Signature ________________________________
(Parent's signature is patient is a minor)

Date ____________________