Modified 06/2016

ESTABLISHED PATIENT HISTORY QUESTIONNAIRE

Last Name: _____ First Name: _____

MI: _____ Preferred Name: _____

Marital status: Divorced / Legally Separated / Married / Single / Widowed

Address: _____ City: _____ State:_____ Zip:_____

Preferred Telephone Number(s): (Cell)_____ (Home)_____

Email Address:_____ Communication Preference: Email / Telephone / Postal

Occupation: _____ Employer/School: _____

If your insurance has changed since your last visit please list your current insurance(s):_____

Subscriber Name_____ Subscriber DOB_____

Medication and Medical History

Current Medication(s): _____

Medication Allergy Y / N Allergic to what? _____

Diabetes Y / N Type: _____ Date of Diagnosis: _____

Have you had any major operations since your last visit? Y/N Type & Year: _____

Name of family doctor: _____ Date of last visit: _____

Do you see an ophthalmologist? Y / N If yes, name of doctor: _____ Date of last visit: _____ / _____ / _____

Review of Ocular System

Have you had any eye operations since your last visit? Y/N Type & Year: _____

Have you had any eye injuries since your last visit? Y/N Type & Year: _____

Do you wear contacts? Y / N What type? _____

Do wear glasses? Y / N Are you interested in contact lenses? Y / N

What are YOUR visual symptoms: Please check any that apply to TODAY'S visit:

[ ] Blurred Vision/Distance	[ ] Dry Eyes	[ ] Headaches	[ ] Itchy Eyes
[ ] Blurred Vision/Near	[ ] Red Eyes	[ ] Migraine Headaches	[ ] Burning Eyes
[ ] Double Vision	[ ] Watery Eyes	[ ] Loss of Vision	[ ] See Halos
[ ] Eye Strain	[ ] Wandering Eye(s)	[ ] Crossed Eyes	[ ] Poor Night Vision
[ ] Eye Infections	[ ] Mucus Discharge	[ ] Light Sensitive	[ ] Droopy Lid
[ ] Eye Pain/Soreness	[ ] Floaters or Spots	[ ] Sandy/gritty Feeling	[ ] Poor Color Vision
[ ] Tired Eyes	[ ] See Flashes		