WELCOME TO OUR OFFICE

Please fill out this questionnaire *carefully* and as thoroughly as possible. There are a total of 5 pages – please be sure you have completed all five pages. You may either print a hard copy and bring it on the day of your appointment or submit online prior to your appointment date. THANK YOU.

Date: ________________

Were you referred to our office? Yes ☐ No ☐

If yes, whom may we thank for this referral? ____

Phone: ____________________ Address: ____

Family ☐ Friend ☐ Doctor ☐ Therapist ☐

Internet ☐ Phone Book ☐ Insurance ☐ Mailing from our office ☐

Other: ____

A. GENERAL INFORMATION

Patient's Full Name: ____

Male ☐ Female ☐ Birth Date: _______________ Social Security Number: ________________

Home Address: ____
Street Apt. #

____
City State Zip Code

Home Phone: __________________________ Work/Daytime Phone: _________________________

Cell Phone: ____________________________ Email Address: _____________________________

Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

What is your occupation? __________________________ Employer: __________________________

Business Address: ____

Spouse's occupation: _____________________________ Employer: __________________________

Spouse Work Phone: _____________________________ Cell Phone: ___________________________

Vision Care Insurance: ________________________ Major Medical Insurance: __________________

Subscriber's SS#/Member ID #: _____________________ Birth Date of Subscriber: ______________

Please list the Names and Birth Dates of other family members still living at home:

Spouse/Partner ______________________________ Birth Date ____________________

Dependent __________________________________ Birth Date ____________________

Dependent __________________________________ Birth Date ____________________

Dependent __________________________________ Birth Date ____________________

Dependent __________________________________ Birth Date ____________________

B. MEDICAL HISTORY

Physician's Name: ___________________________ Date of Last Evaluation: _____________

For what reason: ____

Current state of health: ____

Are you allergic to any foods or medications? Yes ☐ No ☐

If yes, please list: ____

Do you drive? Yes ☐ No ☐

If yes, do you have difficulty driving? _____________________________________

Do you use tobacco products? Yes ☐ No ☐

If yes, what type, amount, how long? ______________________________________

Do you use alcohol? Yes ☐ No ☐

If yes, what type, amount, how long? ______________________________________

Medications Currently Taking (please include all medications, vitamins and over the counter drugs)

	Name:	Dosage:	Reason for Meds:
1.			
2.			
3.			
4.			

Have you ever had any surgical operations or had serious illness or injury? If yes, please list.

	Type of Operation:	Reason:	Date of Operation:
1.			
2.			
3.			

Have you ever had eye surgery? Yes ☐ No ☐

Please indicate by checking the box whether anyone in your family has ever had any of the following and indicate who (including maternal and paternal grandparents, uncles, aunts, first cousins, mother, father, sister and brother):

Amblyopia ☐ ______	Arthritis ☐ ______	Blindness ☐ ______
Brain Tumor ☐ ______	Cancer ☐ ______	Cataracts ☐ ______
Cornea Problems ☐ ______	Corneal Transplant ☐ ______	Crossed/Lazy Eye ☐ ______
Detached Retina ☐ ______	Diabetes ☐ ______	Epilepsy / Seizures ☐ ______
Glaucoma ☐ ______	Heart Problems ☐ ______	High Blood Pressure ☐ ______
Keratoconus ☐ ______	Kidney Problems ☐ ______	Learning Disability ☐ ______
Macular Degeneration ☐ ______	Multiple Sclerosis ☐ ______	Stroke ☐ ______
TB ☐ ______	Thyroid Condition ☐ ______	Traumatic Brain Injury ☐ ______

C. VISUAL HISTORY

Eye Problems or Visual Complaints: ____

____

____

Date of Last Exam: ___________________________ Doctor: _________________________________

Reason for Last Exam: ____

Result of test: ____

Were glasses prescribed in your last exam? Yes ☐ No ☐

If so, what type: Single Vision (distance) ☐ Bifocals ☐ Trifocals ☐ Reading Glasses ☐

Progressive ☐ Occupational ☐ Sunglasses ☐

Are you interested in getting new glasses? Yes ☐ No ☐

Were contacts prescribed in your last exam? Yes ☐ No ☐

If so, what kind: ____

How often are they to be replaced? ____

Are you interested in getting new contact lenses? Yes ☐ No ☐

Contact Lens Policy: If you are requesting a contact lens prescription, our office provides a full service program – evaluation, fitting, and follow-up. Our office does not release the contact lens prescription until you have been successfully evaluated and fitted.

Would you like information about refractive surgery (Lasik)? Yes ☐ No ☐

D. REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:
If YES, please explain and list medications.

SYSTEM	NO	YES	?	EXPLAIN / MEDICATIONS
INTEGUMENTARY	☐	☐	☐	______
NEUROLOGIC				
Headaches	☐	☐	☐	______
Migraines	☐	☐	☐	______
Seizures	☐	☐	☐	______
EYES				
Loss of Vision	☐	☐	☐	______
Blurred Vision	☐	☐	☐	______
Distorted Vision/Halos	☐	☐	☐	______
Loss of Side Vision	☐	☐	☐	______
Double Vision	☐	☐	☐	______
Dryness	☐	☐	☐	______
Mucous Discharge	☐	☐	☐	______
Redness	☐	☐	☐	______
Sandy or Gritty Feeling	☐	☐	☐	______
Itching	☐	☐	☐	______
Burning	☐	☐	☐	______
Foreign Body Sensation	☐	☐	☐	______
Excess Tearing/Watering	☐	☐	☐	______
Glare/Light Sensitivity	☐	☐	☐	______
Eye Pain or Soreness	☐	☐	☐	______
Chronic Infection of Eye or Lid	☐	☐	☐	______
Sties or Chalazion	☐	☐	☐	______
Flashes/Floaters in Vision	☐	☐	☐	______
Tired Eyes	☐	☐	☐	______
EARS, NOSE, MOUTH, THROAT				
Allergies	☐	☐	☐	______
Hay Fever	☐	☐	☐	______
Sinus Congestion	☐	☐	☐	______
Runny Nose	☐	☐	☐	______
Post-Nasal Drip	☐	☐	☐	______
Chronic Cough	☐	☐	☐	______
Dry Throat/Mouth	☐	☐	☐	______
Cold Sores	☐	☐	☐	______
RESPIRATORY				
Asthma	☐	☐	☐	______
Chronic Bronchitis	☐	☐	☐	______
Emphysema	☐	☐	☐	______
Tuberculosis	☐	☐	☐	______

VASCULAR

- Diabetes ☐ ☐ ☐ ______________________
- Heart Pain ☐ ☐ ☐ ______________________
- High Blood Pressure ☐ ☐ ☐ ______________________
- Vascular Disease ☐ ☐ ☐ ______________________

GASTROINTESTINAL

- Diarrhea ☐ ☐ ☐ ______________________
- Constipation ☐ ☐ ☐ ______________________

GENITOURINARY

- Genitals ☐ ☐ ☐ ______________________
- Kidney ☐ ☐ ☐ ______________________
- Bladder ☐ ☐ ☐ ______________________
- Venereal Disease ☐ ☐ ☐ ______________________
- Syphilis ☐ ☐ ☐ ______________________
- Gonorrhea ☐ ☐ ☐ ______________________

BONES/ JOINTS/ MUSCLES

- Rheumatoid Arthritis ☐ ☐ ☐ ______________________
- Muscle Pain ☐ ☐ ☐ ______________________
- Joint Pain ☐ ☐ ☐ ______________________

LYMPHATIC/ HEMATOLOGIC

- Anemia ☐ ☐ ☐ ______________________
- Bleeding Problems ☐ ☐ ☐ ______________________
- HIV ☐ ☐ ☐ ______________________

ENDOCRINE (thyroid/other glands) ☐ ☐ ☐ ______________________

PSYCHIATRIC ☐ ☐ ☐ ______________________

CANCER ☐ ☐ ☐ ______________________