

Patient History Questionnaire

(must be updated at each visit)

MR
MRS
Last Name: MS First Name _____ MI _____ Today's Date: ____/____/____
DR

Address: _____ City: _____ State _____ Zip _____

Telephone: (H) _____ (W) _____ (cell) _____

Date of Birth: _____ Social Security No.: _____ - _____ - _____

Patient Occupation: _____ Employer: _____

If Student, Name of School: _____ Emergency Telephone No.: _____

Your E-mail Address: _____

Date of Last Eye Exam: _____ Date of Last Spectacles/Contact Lens Rx: _____

Spouse: _____ Name Parent, if minor: _____

Medical Information

What is your general health? _____

Do you have any problems with any of these systems? (please circle all that apply)

Gastrointestinal	Y/N	Neurological	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Psychiatric	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine (glands)	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Blood/Lymph	Y/N
Constitution (fever, weightloss/gain)	Y/N			Allergic/Immunologic	Y/N

If Yes, Please Explain: _____

Please Answer all that apply:

Diabetes Y/N Type _____ Date of Diagnosis _____

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

Allergies to medications? Y/N What happens? _____ Headaches Y/N

Other health problems _____

Current medication(s) _____

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

Social History

(This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer)

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check Box)

Hobbies, Sports and Other Interests _____

Do you drive? Y/N If yes, do you have visual difficulty when driving? Y/N If yes, please describe _____

Do you use computers? Y/N If yes, how many hours per day _____

Do you use tobacco products? Y/N If yes, type/amount/how long: _____

Do you drink alcohol? Y/N If yes, type/amount/how long: _____

Do you have a substance abuse problem? Y/N If yes, type/amount/how long: _____

please turn over

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 _____ Cataracts Y/N Relation _____
Other Eye Condition(s) Y/N What kind? _____ Relation _____
Other System Disease(s) Y/N What kind? _____ Relation _____

Personal Eye Information

Have you had any eye operations? Y/N Type _____ Date _____
Have you had an eye injury? Y/N Kind _____ Date _____

Do you have glaucoma? Y/N	Cataracts? Y/N	Any Other Eye Problems	Y/N
Eyes	Do you have any of these problems with your eyes		
Loss of Vision	Y/N	Itching	Y/N
Blurred Vision	Y/N	Burning	Y/N
Distorted Vision/Halos	Y/N	Foreign Body Sensation	Y/N
Loss of Side Vision	Y/N	Excess Tearing/Watering	Y/N
Double Vision	Y/N	Glare/Light Sensitivity	Y/N
Dryness	Y/N	Eye Pain or Soreness	Y/N
Mucous Discharge	Y/N	Chronic Infection of Eye or Lid	Y/N
Redness	Y/N	Sties or Chalazion	Y/N
Sandy or Gritty Feeling	Y/N	Flashes/Floaters in Vision	Y/N
Crossed Eyes	Y/N	Tired Eyes	Y/N

If you answered YES to any of the above or have a condition not listed, please explain and list medications: _____

Are you planning to get new glasses today? Y/N Only if Rx changes

Have you worn contact lens in the past? Y/N Type _____

Are you planning to get new contacts today? Y/N Only if Rx changes

Are you interested in finding out more about corneal refractive therapy (CRT) or laser vision correction? Y / N / Maybe

Insurance companies cover visual exams for eyeglasses only. If you are interested in contact lenses, services start at \$45.00.

Insurance

Insurance Carrier _____ Policy _____
Subscriber Name _____ Relationship to Patient _____
Membership Number _____ Secondary Insurance _____

Referral Information

How did you learn about our office (Please circle the appropriate sources that apply)

Relative Friend Yellow Pages Internet HMO - Insurance Location Safety Exam Newspaper Other

List family members (relationship) who are patients in this office _____

If you are a new patient, who may we thank for referring you to this office? _____

I hereby authorize any necessary medical treatment by the optometrists in the practice of Drs. Jaffe and Clanton and agree to be responsible for my bill and any collections fees made necessary to collect payment of services rendered.

Patient's signature _____ Date _____