Patient History Questionnaire

Patient Name:____ Today's Date: ___/___/___

Street Address:______________________________________ Phone #:____________________

City:________________________ State:______ Zip:_________ Work Phone #:______________

Date of Birth: ___/___/___ Marital Status:____________________ Occupation:________________

Primary Care Physician:________________________________ Last Eye Exam: ___/___/___

How did you hear about us?_____________________________ E-mail:____________________

If we need to contact you, do you prefer to be reached at □ E-mail or □ Phone?

Medical History

Current Medications:____

Known Allergies:____

Have you ever experienced any of the following? __ Eye Injury __Eye Surgery __Head Trauma __Eye Patching

__Flashes of Light __Floaters __Double Vision

Have you been diagnosed with, or have a known family history of, any of the following?

__ Cataracts __Diabetes __Retinal Detachment __Lazy Eye __Blindness

__Hypertension __Glaucoma __Macular Degeneration

If yes to any of the above, please explain:____

Review of Systems

Are you currently experiencing, or have a chronic condition related to, any of the following?:

	NO	YES
CONSTITUTIONAL		
Fever, Weight Loss/Gain	__	__
INTEGUMENTARY (Skin)	__	__
NEUROLOGICAL		
Headaches	__	__
Migraines	__	__
Seizures	__	__
ENDOCRINE		
Thyroid/Other Glands	__	__
VASCULAR/CARDIOVASCULAR		
Diabetes	__	__
Heart Pain	__	__
High Blood Pressure	__	__
Vascular Disease	__	__
BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	__	__
Muscle Pain	__	__
Joint Pain	__	__
ALLERGIC/IMMUNO.	__	__

	NO	YES
EARS, NOSE, MOUTH, THROAT		
Allergies, Hay Fever	__	__
Sinus Congestion	__	__
Post-Nasal Drip	__	__
Chronic Cough	__	__
Dry Throat/Mouth	__	__
RESPIRATORY		
Asthma	__	__
Chronic Bronchitis	__	__
Emphysema	__	__
GASTROINTESTINAL		
Diarrhea	__	__
Constipation	__	__
GENITO-URINARY		
Genitals/Kidney/Bladder	__	__
LYMPHATIC/HEMATOLOGIC		
Anemia	__	__
Bleeding Problems	__	__
PSYCHIATRIC	__	__

If you answered YES to any of the above, please explain:______________________________________

Do you use tobacco products? __NO __YES If yes, type/amount, how long: ____________________________

Do you drink alcohol? __NO __YES If yes, type/amount, how long:____________________________

Do you use recreational drugs? __NO __YES If yes, type/amount, how long:____________________________

Are you currently pregnant and/or nursing? __NO __YES

Insurance Information

Vision Insurance Plan: ________________________ ID#:______________________ Name of Policy Holder:_______________________

Relationship to Insured:_______________________ Policy Holder's DOB:___/___/___ Policy Holder's SS#:_________________________

Medical Insurance Plan:_______________________ ID#:______________________ Name of Policy Holder:________________________

Relationship to Insured:_______________________ Policy Holder's DOB:___/___/___ Policy Holder's SS#:_________________________

Race: __American Indian/Alaska Native __ Asian

__ Native Hawaiian/Pacific Islander __ Black/African American

__ White __Hispanic/Latino __ Other

Preferred Language:________________________________

Eyewear/Lifestyle Questionnaire

Your answers to these questions will guide us in recommending the best products to meet your eyewear needs.

Do you currently wear prescription glasses? __________ Do you currently wear contacts? ___________

What percent of the time do you wear your glasses? ________ Contacts? ________

Do you wear prescription sunglasses? ________ Non-prescription sunglasses? _______

When do you wear your corrective eyewear?

	Glasses	**Sunglasses**	**Contacts**
All of the time	_____	_____	_____
For reading/working	_____	_____	_____
For Driving	_____	_____	_____
For sports/recreation	_____	_____	_____
Other:____________	_____	_____	_____

Which of the following do you do regularly? (Check all that apply)

□ Night Driving □ Work outdoors □ Commute 20+ min. by car

□ Work w/ small objects □ Work under fluorescent light □ Read for long periods

□ Work on a computer □ Travel on airplanes □ Watch TV for 3+ hours a day

□ Work at a desk □ Frequently alternate between indoors & outdoors

Please list the sports and hobbies in which you participate: ____

What do you like about your current glasses? ____

Are you planning on ordering new glasses and/or sunwear today? □ Yes □ No