



Janet Corbit-Drakulich, O.D., M.Ed. • 3033 N. Carson St., • Carson City, NV 89706 • 775.887.8866 • Fax 775.461.0299

Patient History Questionnaire

Date: _____ Last Name: _____ First Name: _____ Middle Initial _____
 Parent Name (if applicable): _____
 Date of Birth: _____ Age: _____ Ethnicity: _____ Gender: M / F If female, are you pregnant: Y / N Marital Status: S / W / M / D
 Address: _____ City/State/Zip: _____
 Phone (home): _____ Phone (work): _____
 Email: _____ (By filling this in, you agree to receive emails from The See Center, such as appointment reminders and information on eye health topics, etc. Your email will not be shared with others and will be used responsibly).
 Emergency Contact & Telephone Number: _____

Name of person responsible for payment: _____
 Name of vision &/or medical coverage: _____
 Name of Insured: _____ Insurance ID Number: _____

I understand that if for any reason my expenses are not covered by insurance or another source, I am responsible for payment in full. Signature: _____ **Date:** _____

How did you hear about us? The See Center Website Insurance or other website Online Yellow Page Directory
 Telephone Book Brochure Newspaper Direct Mail
 Referral (name of person/physician/insurance): _____ Other (list): _____

What is the reason for today's visit? _____
 Type of exam: Glasses Contact lenses Both
 Are you interested in refractive surgery (i.e. LASIK)? Yes No
 When was your last eye exam? _____ Name of Clinic or Doctor: _____
 Do you wear: Glasses Contact lenses Neither Both
 Are they for: Distance Close up (near) Both
 How do you use your eyes (name your occupation &/or hobby)? _____

Have you ever had:	Yes	No	What	When
Eye injury				
Eye surgery				
Eye infection				

Do you or does anyone in your immediate family have any of the following? If no conditions apply, check here:

<input type="checkbox"/> Glaucoma	Who: _____	<input type="checkbox"/> Lazy Eye	Who: _____
<input type="checkbox"/> Macular Degeneration	Who: _____	<input type="checkbox"/> Eye Turn (crossed or misaligned)	Who: _____
<input type="checkbox"/> Blindness	Who: _____	<input type="checkbox"/> Other Eye Conditions: _____	Who: _____

Do you currently, or have you ever had, problems with your eyes in any of the following areas (please circle):

itching burning excess tearing redness sandy/gritty feeling dryness mucous discharge glare/light sensitivity

eye pain/soreness chronic infection sties flashes of light floaters distorted vision/halos blurred vision loss of vision

double vision tired eyes eye strain with computers poor night vision poor depth perception low reading comprehension

When was your last medical exam? _____ Who was your physician? _____

List all medications you take (including prescription and non-prescription medications, birth control pills, eye drops, vitamins and herbal supplements/home remedies): _____

List all major injuries, surgeries &/or hospitalizations: _____

List any known allergies to medications and the type of reaction (rash, swelling, difficulty breathing, anaphylaxis) you had: _____

Do you currently, or have you ever had, any problems in the following areas:

System	Yes	No	If yes, please explain
<u>Allergic / Immune System Disorder</u> hay fever, allergies			
<u>Bones / Joints / Muscles</u> rheumatoid arthritis, muscle/joint pain, swollen joints			
<u>Cardiovascular</u> chest pain, heart problems, high blood pressure, high cholesterol, circulatory or vascular disease, stroke			
<u>Constitutional (Current Problems)</u> fever, unexplained weight change, fatigue, other			
<u>Ear, Nose and Throat</u> sinus congestion, runny nose, chronic cough, dry mouth			
<u>Endocrine</u> diabetes, thyroid, other glands, neck pain			
<u>Gastrointestinal</u> heartburn, acid reflux, abdominal pain, recurrent diarrhea			
<u>Genitourinary</u> genitals, kidney or bladder problems			
<u>Integumentary (Skin)</u> rashes, excessive dryness, itching			
<u>Lymphatic / Hematologic</u> anemia, blood disorders, bleeding problems			
<u>Nervous System</u> headaches, numbness, weakness, paralysis, dizziness, motion sickness, seizures, multiple sclerosis			
<u>Psychiatric / Emotional / Mental</u> anxiety, depression, ADHD, special needs			
<u>Respiratory</u> shortness of breath, wheezing, coughing, asthma, chronic bronchitis, emphysema			
<u>Other</u> cancer, other conditions not listed			

Does, or did, anyone in your immediate family have any of the following conditions? If no conditions apply, check here:

<input type="checkbox"/> Diabetes	Who: _____	<input type="checkbox"/> Arthritis	Who: _____
<input type="checkbox"/> High blood pressure	Who: _____	<input type="checkbox"/> Migraines	Who: _____
<input type="checkbox"/> Thyroid disorder	Who: _____	<input type="checkbox"/> Cancer	Who: _____

This information is kept strictly confidential. Do you: Use tobacco Drink alcohol Use recreational/illicit drugs None

Are you: Current Smoker Former Smoker Never Smoked

If yes, please give the type, frequency, amount, and duration (how long): _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Patient (or parent) signature: _____ Date: _____

Doctor's Initials: _____ Date: _____