

PATIENT INFORMATION QUESTIONNAIRE

Appointment Reminder Preference: Text or Email

Please Circle One

Date _____ DOB _____ Age _____ Preferred Name _____
Last Name _____ First Name _____ Middle Initial _____
Street Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Preferred Method of Contact: Home or Cell
Work Phone _____ Email Address _____
Social Security (Last 4) _____ Occupation _____
Emergency Contact _____ Contact Phone _____ Relationship _____
May we speak with your Emergency Contact about your Appointments/Health Medical Information? _____

MEDICAL INFORMATION

Insurance Plan _____ Policy # _____ Primary/DOB _____

What is your general health? _____

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

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine (glands)	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Blood/Lymph	Y/N
				Allergic/Immunologic	Y/N

Please explain _____

Please answer all that apply:

Diabetes Y/N Type _____ Date of diagnosis _____

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

Medication allergy Y/N Type of Medication? _____ What happens? _____

Other Health Problems _____

Current Medication(s) _____

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

Do you use cigarettes/tobacco? Y/N Alcohol? Y/N Other substance(s) _____

Family doctor _____ Phone Number _____ Date of Last Visit _____

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 _____

PERSONAL EYE INFORMATION

Date of last eye exam? Month _____ Year _____

Have you had any eye operations? Y/N _____ Date _____

Have you had an eye injury? Y/N _____ Date _____

Do you have Dry eyes? Y/N Glaucoma? Y/N Cataracts? Y/N Blurred Vision Y/N

Do you wear glasses? Y/N Contact Lenses? Y/N Type _____

Additional information _____

Whom may we thank for referring you? _____

Signature: _____ Confirmed _____ Appointment _____

Please Check to Confirm