Patient Information and Medical History Questionnaire

Name	Date					
Address	Name			· · · · · · · · · · · · · · · · ·		
Phone (H)(W)(C)					•	
Birth date	Address		City		State	Zip
Cocupation	Phone (H)	(W)	((C)	E-mail	
Insurance Company	Birth date	Age_	Male	☐ Female Soci	al Security #	
Insurance Company	Occupation			Employer		
How were you referred to our office? Previous Patient Drive by Advertising Website Doctor Referral Yellow Pages Other A Satisfied Patient (Who may we thank?) Ocular History Date of last eye exam Check any of the following which may apply: Crossed eyes Retinal Disease Double Vision Dryness Buming Sensitivity to Light Lazy eye Cataracts Floaters Redness Foreign Body Tired Eyes Drooping Eyelid Eye Infections Loss of Vision Mucous Discharge Excess Tearing Prominent Eyes Eye Injury Blurred vision Standy/Gritty Feeling Eye Pain Glaucoma Flashes of Light Halos Itching Stye/Chalazion No Yes Flyes, how old is your present pair of lenses? Does glare from oncoming headlights or your computer bother you? No Yes Doy ou wear contact lenses? No Yes If yes, how old is your present pair of lenses? Type of Contact lenses: Rigid Gas Permeable Soft Soft Disposable replace every Other Other						
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Check any of the following which may apply: Crossed eyes	a renow rages	u ouici	a A Satisti			(who may we thank.,
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Crossed eyes		•		-		
Crossed eyes	Chack any of the fo	llowing which may ar	only:			
Lazy eye				□ Dermoce	□ Durning	☐ Sancitivity to Light
□ Drooping Eyelid □ Eye Infections □ Loss of Vision □ Mucous Discharge □ Excess Tearing □ Prominent Eyes □ Eye Injury □ Blurred vision □ Sandy/Gritty Feeling □ Eye Pain □ Glaucoma □ Flashes of Light □ Halos □ Itching □ Stye/Chalazion □ Doyou wear glasses? □ No □ Yes If yes, how old is your present pair of lenses? □ Does glare from oncoming headlights or your computer bother you? □ No □ Yes □ Doyou wear contact lenses? □ No □ Yes If yes, how old is your present pair of lenses? □ Type of Contact lenses: □ Rigid Gas Permeable □ Soft □ Soft Disposable □ replace every □ □ Other Are they comfortable: □ No □ Yes □ Please check any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions: Disease/Condition Relationship to you □ Disease/Condition Relationship to you □ Blindness □ □ Cataract □ Crossed Eyes □ □ Glaucoma □ Retinal Detachment/ Disease □ Arthritis □ □ Cancer □ Diabetes □ □ Heart Disease □ Kidney Disease	N AL COL 47544 - 4502 () Al COL• NOTICE				-	
□ Halos □ Itching □ Stye/Chalazion Do you wear glasses? □ No □ Yes If yes, how old is your present pair of lenses? □ Does glare from oncoming headlights or your computer bother you? □ No □ Yes Do you wear contact lenses? □ No □ Yes If yes, how old is your present pair of lenses? □ Type of Contact lenses: □ Rigid Gas Permeable □ Soft □ Soft Disposable I replace every □ □ Other Are they comfortable: □ No □ Yes Family History Please check any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions: Disease/Condition Relationship to you □ Disease/Condition Relationship to you □ Blindness □ □ Cataract □ Crossed Eyes □ □ Glaucoma □ Macular Degeneration □ □ Retinal Detachment/ Disease □ Arthritis □ □ Cancer □ Diabetes □ □ Heart Disease □ Kidney Disease	☐ Drooping Eyelid					
Do you wear glasses?	☐ Eye Injury		☐ Sandy/Gritty Feeling	ng 🗆 Eye Pain	☐ Glaucoma	☐ Flashes of Light
Does glare from oncoming headlights or your computer bother you?	☐ Halos	☐ Itching	☐ Stye/Chalazion			
Does glare from oncoming headlights or your computer bother you?	Do you wear glasse	s? 🗆 No 🗇 Yes If	ves how old is your pr	esent nair of lenses?		
Do you wear contact lenses?						
Type of Contact lenses:					lenses?	
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Please check any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions: Disease/Condition Relationship to you Disease/Condition Relationship to you Blindness Galaucoma Galaucoma Retinal Detachment/ Disease Arthritis Gancer Diabetes Gancer High Blood Pressure Kidney Disease						
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