Patient History Questionnaire

Full Name: _____ Birth Date ___/___/_____

Address: _____

Email Address: _____ Home Phone: _____

Occupation: _____ Cell Phone: _____

Medical Doctor: _____ Last Eye Exam: _____

Vision Insurance: _____ _ Medical Insurance: _____

Ocular History

Do you wear glasses: Yes ☐ No ☐ If yes, how old is your present pair of lenses? _____

Do you wear contacts: Yes ☐ No ☐ If yes, what type? Rigid ☐ Soft ☐ Multifocal ☐

Sleep in contacts? Yes ☐ No ☐ How often do you replace them? _____

Have you ever had any eye surgeries? Yes ☐ No ☐ If yes, when and what for _____

Do you use eye drops? Yes ☐ No ☐ If yes, what type and how often? _____

Are you currently experiencing any of the following problems with your eyes? **Check the box if Yes**

☐ Blurred vision	☐ Excess Tearing/Watering	☐ Loss of side vision
☐ Burning	☐ Flashes/floaters in Vision	☐ Mucous Discharge
☐ Double Vision	☐ Glare/Light Sensitivity	☐ Redness
☐ Dryness	☐ Itching	☐ Sandy/Gritty Feeling
☐ Eye pain	☐ Loss of vision	☐ Styes/Eyelid bumps

Have you been diagnosed with any of the following problems? **Check the box if Yes**

☐ Cataracts	☐ Eye Injury	☐ Macular Degeneration
☐ Crossed Eyes	☐ Glaucoma	☐ Retinal Detachment/Disease
☐ Dry Eye	☐ Lazy Eyes	☐ Other_____

Medical History

List any medications you are currently taking (including oral contraceptives, aspirin, over-the-counter medications) _____

_____

_____

Are you allergic to any medications? Yes ☐ No ☐ If yes, which ones: _____

List all major injuries, surgeries, and/or hospitalizations you have had _____

_____

Review of Systems Please check the box beside any problems you have, or have had in the past:

Allergic/Immunologic ☐ All Normal
☐ Allergy/Hay fever

Cardiovascular/Cardiac ☐ All Normal
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol

Constitutional ☐ All Normal
☐ Fever
☐ Weight Loss/ Gain

Ears, Nose,Throat ☐ All Normal
☐ Sinus Congestion
☐ Dry Mouth/Throat

Endocrine ☐ All Normal
☐ Diabetes
☐ Thyroid Disease

Gastrointestinal ☐ All Normal
☐ Colitis
☐ IBS/ Crohn's Disease
☐ Ulcers

Genitourinary ☐ All Normal
☐ Kidney Disease
☐ Ovarian/ Uterine Cancer
☐ Prostate Cancer

Hematologic/ Lymphatic ☐ All Normal
☐ Anemia
☐ Bleeding Problems
☐ Breast Cancer

Skin ☐ All Normal
☐ Cancer
☐ Rashes
☐ Easy Bruising

Musculoskeletal ☐ All Normal
☐ Rheumatoid Arthritis
☐ Muscle Pain
☐ Fibromyalgia

Neurological ☐ All Normal
☐ Migraines/ Headaches
☐ Stroke
☐ Seizures

Psychiatric ☐ All Normal
☐ Anxiety
☐ Depression
☐ Memory Loss

Respiratory ☐ All Normal
☐ Asthma
☐ Bronchitis/ Emphysema

If you checked any of the above boxes or have a condition not listed, please explain further: _____
_____

_____

Are you pregnant and/or nursing? Yes ☐ No ☐

Do you use tobacco products? Yes ☐ No ☐ If yes, type/amount/how long _____

Do you drink alcohol? Yes ☐ No ☐ If yes, type/amount/how long _____

Do you use illegal drugs? Yes ☐ No ☐ If yes, type/amount/how long _____

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

Family History Please note any family history (parents, grandparents, siblings; living or deceased) for the following conditions:

	Relation to you		**Relation to you**
☐ Glaucoma	_____	☐ Diabetes	_____ _____
☐ Retinal Detachment	_____	☐ Cancer	_____
☐ Macular Degeneration	_____	☐ Heart Disease	_____
☐ Blindness	_____	☐ High Blood Pressure	_____
☐ Crossed Eyes	_____	☐ Kidney Disease	_____

Patient Financial Responsibility

Medical Insurance: We have contracts with many insurance companies and we bill them as a service to you. However, as the responsible party, you are ultimately responsible if your insurance company declines to pay for any reason. By signing below, you accept this responsibility and will pay any balance due within 30 days of notification.

Patient Signature: _____

Acknowledgement Of Receipt

I acknowledge that I have been offered a copy of the Allentown Vision Center's (AVC) Notice of Privacy Practices.

> It tells me how AVC will use my health information for the purposes of my treatment, payment for my treatment, and AVC's health care operations.
>
> AVC will also use and share my health information as required/permitted by law.

Patient Signature: _____