Patient History Questionnaire

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ______________________________ / /

Last Name First Name MI Birth Date

Address ______________________________

Street Address City State Zip Code

Phone Home __________ Work __________ Cell __________

Email __________ Social Security # __________

Occupation __________ Employer __________

(OR FORMER) Spouse __________ (OR FORMER) Employer __________

Responsible Party __________ Hobby/Interests __________

Medical Insurance __________ Vision Insurance __________

Primary Care Doctor __________ Phone Number __________

Emergency Contact __________ Phone Number __________

Personal Eye Information

Last Eye Exam Date __________ Have your eyes been dilated before? ☐ Yes ☐ No

Have you had any eye surgeries? ☐ Yes ☐ No Type __________

Have you had any eye injuries? ☐ Yes ☐ No Type __________

Do you have any of the following? ☐ Glaucoma ☐ Cataracts ☐ Dry Eye ☐ Blurred Vision

Please explain any other problems __________

Do you wear any: ☐ Glasses Type ☐ Single Vision ☐ Bifocal or Progressive

☐ Contact Lenses Type ☐ Soft Lenses ☐ Gas-Permeable (rigid)

Would you like new glasses? ☐ Yes ☐ No How old is your prescription? __________

Do your glasses have prism? ☐ Yes ☐ No Do you drive a vehicle? ☐ Yes ☐ No

Who can we thank for referring you? __________

Certification

I assign my insurance coverage directly to Dr. Jones or Dr. Serdahl for all surgical and medical benefits that are payable to me for services rendered. I understand that my insurance may deny coverage of any or part of any services rendered, such as the refraction fee or exam co-pays, and that I am fully responsible for any charges not covered by insurance. With any services rendered, there is no guarantee of a successful outcome. All service fees are non-refundable.

I understand that is my responsibility to check-in for my appointment at the scheduled time, and that my exam may not start at the appointed time. Cancellations or reschedules for appointments must be received 24 hours in advance; otherwise I agree to pay a $25.00 no-show charge.

Date

☐ No Change __________

☐ No Change __________

Signed __________ Date __________ ☐ No Change __________

Review of Systems

How would you describe your general health? ______________________

Do you have any problems with any of these systems? Please circle all that apply and explain.

Eyes	______	Glands	______
Digestive	______	Skin	______
Nervous	______	Heart	______
Mental	______	Muscle/Bone	______
Lungs/Breathing	______	Blood/Lymph	______
Ear/Nose/Throat	______	Allergy/Immune	______
Genitals/Urinary	______	Other	______

Personal and Family Medical History

Do you or any of your family members have any of the following conditions?

Condition	Personal History	Family History	Relationship
Amblyopia	☐ Yes ☐ No	☐ Yes ☐ No	______
Cataracts	☐ Yes ☐ No	☐ Yes ☐ No	______
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	______
Dry Eyes	☐ Yes ☐ No	☐ Yes ☐ No	______
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No	______
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No	______
Macular Degeneration	☐ Yes ☐ No	☐ Yes ☐ No	______
Migraines	☐ Yes ☐ No	☐ Yes ☐ No	______
Retinal Detachment	☐ Yes ☐ No	☐ Yes ☐ No	______

Please list all medications ______________________

____

____

Please list all vitamins/herbs ______________________

Please list any surgeries ______________________

____

Please list any allergies (including medications) ______________________

Social History

Do you use cigarettes/tobacco? ☐ Yes ☐ No	Packs per day	______
Do you use alcohol? ☐ Yes ☐ No	Drinks per day	______
Do you use any other substances? ☐ Yes ☐ No	Type/Frequency	______