Patient Information Questionnaire

Today's Date_____ Date of Birth_____/_____/_____Age_____

Patient Name_____Height_____Weight_____lbs

SSN_____-_____-_____

Address_____City _____State_____Zip Code_____

Phone: Cell_____Home_____Work_____

Email_____Preferred method of contact: Cell Home Work Email

Reason for today's visit _____

How did you hear about us? _____

Who is your primary care physician? _____ Clinic _____

Payment Information

Responsible Party_____Relationship to Patient_____

Responsible Party's SSN_____

Responsible Party's Date of Birth_____/_____/_____

_____Private or Self Pay

Vision Insurance _____Medical Insurance_____

Company/Employer_____

Contact Lenses

Do you wear contacts? _____If no, are you interested in trying contacts? _____

If yes, what brand of contacts do you wear?_____

How many hours a day?_____How many days a week?_____

How often do you sleep in them?_____

How often to you replace them?_____

Are you interested in Laser Corrective Surgery (LASIK)?_____

Do you wear UV protection?_____

Do you use tobacco?_____How much?_____ Have you ever used tobacco?_____

What kind, cigarettes, cigar, pipe, smokeless?_____

Do you drink alcohol?_____If yes, how much?_____

How much time do you spend on the computer a day?_____

Do you participate in any sports? If yes, please list_____

What are your hobbies?_____

Medical History

Do you have any Allergies?_____If yes, please list_____

Are you taking any medications? If yes, please list_____

Family includes parents, grandparents, siblings, and children

You Family

Constitution

□ □ Developmental Disability
□ □ Cancer
□ □ Fatigue Syndrome
□ □ Weight Loss/Gain
□ □ _____

Ear, Nose, Mouth & Throat

□ □ Hearing Loss
□ □ Sinusitis
□ □ Dry Mouth
□ □ Laryngitis
□ □ _____

Neurological

□ □ Multiple Sclerosis
□ □ Epilepsy
□ □ Cerebral Palsy
□ □ Tumor
□ □ Stroke/CVA
□ □ _____

Psychiatric

□ □ Depression
□ □ Attention Deficit
□ □ Anxiety Disorder
□ □ Bipolar Disorder
□ □ Schizophrenia
□ □ _____

Cardiovascular

□ □ Hypertension
□ □ Stroke/CVA
□ □ Heart Disease
□ □ Vascular Disease
□ □ Congestive Heart Failure
□ □ _____

You Family

Respiratory

□ □ Asthma
□ □ Bronchitis
□ □ Emphysema
□ □ COPD
□ □ Sleep Apnea
□ □ _____

Gastrointestinal

□ □ Crohn's Disease
□ □ Colitis
□ □ Ulcer
□ □ Acid Reflux
□ □ Celiac Disease
□ □ _____

Genitourinary

□ □ Kidney Disease
□ □ Prostate Disease/Cancer
□ □ STD
□ □ Benign Prostate Hypertrophy
□ □ Pregnant/Nursing
□ □ _____

Musculoskeletal

□ □ Arthritis
□ □ Osteoarthritis
□ □ Fibromyalgia
□ □ Muscular Dystrophy
□ □ Ankylosing Spondylitis
□ □ Osteoporosis
□ □ Gout
□ □ _____

Integumentary

□ □ Eczema
□ □ Rosacea
□ □ Psoriasis
□ □ Herpes Simplex/Cold Sores
□ □ Herpes Zoster/Shingles
□ □ _____

You Family

Endocrine

□ □ Type 2 Diabetes
□ □ Type 1 Diabetes
□ □ Thyroid Dysfunction
□ □ Hormonal Dysfunction
□ □ _____

Hematological/ Lymphatic

□ □ Anemia
□ □ Large Volume Blood Loss
□ □ High Cholesterol
□ □ _____

Allergic/Immune

□ □ Rheumatoid Arthritis
□ □ Lupus
□ □ Sjogren's Syndrome
□ □ _____

Eyes

□ □ Glaucoma
□ □ Glaucoma Suspect
□ □ Cataract
□ □ Age-related Macular Degeneration
□ □ Surgery
□ □ Patching
□ □ Inflammatory Disorder
□ □ Strabismus
□ □ Amblyopia
□ □ Retinal Hole/Detachment
□ □ Retinal Degeneration
□ □ Keratoconus
□ □ Injury
□ □ Dry Eye
□ □ Nystagmus
□ □ _____