PATIENT HISTORY QUESTIONNAIRE

EYEWORKS LOUISVILLE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Today's Date_____/_____/_____ Date of last exam_____ Referred by_____

Last Name_____ First_____ MI_____

Address_____ City_____ State_____ Zip_____

Work Phone (____)_____ Home Phone (____)_____ Cell Phone (____)_____

E-Mail_____

DOB____/____/_____ Occupation_____ Employer_____ Gender M F

Name of Insured_____ Relationship to patient_____

Insured birth date_____/_____/_____ Insured SSN_____-_____-_____ Patient SSN_____-_____-_____

Address_____ City_____ State_____ Zip_____

Medical Insurance Co._____ ID#_____ Group #_____

Vision Insurance Co._____

MEDICAL INFORMATION

What is your general health_____ Are you pregnant?_____

Do you have problems with any of the following (Please circle yes or no)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscle/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Skin	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain _____

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MEDICAL INFORMATION (CONTINUED)

Diabetes Yes/No Type_____ Date of diagnosis____/_____/_____

Allergies to Medications Yes/No Which?_____ Reactions_____

Other Health Problems _____

Any current medications Yes/No Please List_____

Have you had any operations? Yes/No PLEASE LIST_____ When_____/_____/_____

Name of family doctor_____ Date of last visit_____/_____/_____

FAMILY HISTORY

High blood pressure	Yes/No	Relation_____	Macular degeneration	Yes/No	Relation_____
Diabetes	Yes/No	Relation_____	Retinal detachment	Yes/No	Relation_____
Glaucoma	Yes/No	Relation_____	Cataracts	Yes/No	Relation_____

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? Yes/No What kind?_____

Have you had any eye operations? Yes/No Type_____ Date_____/_____/_____

Have you had an eye injury? Yes/No Kind_____ Date_____/_____/_____

Do you have glaucoma? Yes/No Cataracts? Yes/No Dry Eyes? Yes/No

Macular degeneration? Yes/No Retinal detachment Yes/No Blurred vision Yes/No

Do you wear glasses? Yes/No Contact lens? Yes/No Type_____

Additional information _____

Payment is required at time of service. If possible we will try to bill your insurance company. There are times when a representative from your insurance company gives erroneous information pertaining to your actual coverage. You are ultimately responsible if your insurance does not pay. You insurance copay covers only the basic eye examination. The contact lens evaluation is an additional charge and is not covered by the insurance copay. I understand the above statements.

Signature_____Date_____

Relationship to Patient_____