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Patient History Questionnaire

Date:_____Last Name:_____First Name: _____Middle Initial_____
Parent Name (if applicable):_____
Date of Birth: _____Age:____ Ethnicity: ____Gender: M / F If female, are you pregnant: Y / N Marital Status: S / W / M / D
Address: _____City/State/Zip: _____
Phone (home): _____Phone (work): _____
Email: _____ (By filling this in, you agree to receive emails from The See Center, such as appointment reminders and information on eye health topics, etc. Your email will not be shared with others and will be used responsibly).
Emergency Contact & Telephone Number: _____

Name of person responsible for payment: _____
Name of vision &/or medical coverage: _____
Name of Insured: _____ Insurance ID Number: _____

I understand that if for any reason my expenses are not covered by insurance or another source, I am responsible for payment in full. Signature: _____ Date: _____

How did you hear about us? □ The See Center Website □ Insurance or other website □ Online Yellow Page Directory
□ Telephone Book □ Brochure □ Newspaper □ Direct Mail
□ Referral (name of person/physician/insurance): _____ □ Other (list): _____

What is the reason for today's visit? _____
Type of exam: □ Glasses □ Contact lenses □ Both
Are you interested in refractive surgery (i.e. LASIK)? □ Yes □ No
When was your last eye exam? _____ Name of Clinic or Doctor: _____
Do you wear: □ Glasses □ Contact lenses □ Neither □ Both
Are they for: □ Distance □ Close up (near) □ Both
How do you use your eyes (name your occupation &/or hobby)?_____

Have you ever had:	Yes	No	What	When
Eye injury				
Eye surgery				
Eye infection				

Do you or does anyone in your immediate family have any of the following? If no conditions apply, check here: □

□ Glaucoma Who: _____ □ Lazy Eye Who: _____
□ Macular Degeneration Who: _____ □ Eye Turn (crossed or misaligned) Who: _____
□ Blindness Who: _____ □ Other Eye Conditions: _____ Who: _____

Do you currently, or have you ever had, problems with your eyes in any of the following areas (please circle):

itching burning excess tearing redness sandy/gritty feeling dryness mucous discharge glare/light sensitivity

eye pain/soreness chronic infection sties flashes of light floaters distorted vision/halos blurred vision loss of vision

double vision tired eyes eye strain with computers poor night vision poor depth perception low reading comprehension

When was your last medical exam?_____Who was your physician?_____

List all medications you take (including prescription and non-prescription medications, birth control pills, eye drops, vitamins and herbal supplements/home remedies): _____

_____

List all major injuries, surgeries &/or hospitalizations: _____

_____

List any known allergies to medications and the type of reaction (rash, swelling, difficulty breathing, anaphylaxis) you had: _____

_____

Do you currently, or have you ever had, any problems in the following areas:

System	Yes	No	If yes, please explain
Allergic / Immune System Disorder hay fever, allergies			
Bones / Joints / Muscles rheumatoid arthritis, muscle/joint pain, swollen joints			
Cardiovascular chest pain, heart problems, high blood pressure, high cholesterol, circulatory or vascular disease, stroke			
Constitutional (Current Problems) fever, unexplained weight change, fatigue, other			
Ear, Nose and Throat sinus congestion, runny nose, chronic cough, dry mouth			
Endocrine diabetes, thyroid, other glands, neck pain			
Gastrointestinal heartburn, acid reflux, abdominal pain, recurrent diarrhea			
Genitourinary genitals, kidney or bladder problems			
Integumentary (Skin) rashes, excessive dryness, itching			
Lymphatic / Hematologic anemia, blood disorders, bleeding problems			
Nervous System headaches, numbness, weakness, paralysis, dizziness, motion sickness, seizures, multiple sclerosis			
Psychiatric / Emotional / Mental anxiety, depression, ADHD, special needs			
Respiratory shortness of breath, wheezing, coughing, asthma, chronic bronchitis, emphysema			
Other cancer, other conditions not listed			

Does, or did, anyone in your immediate family have any of the following conditions? If no conditions apply, check here: □

□ Diabetes Who: _____ □ Arthritis Who: _____

□ High blood pressure Who: _____ □ Migraines Who: _____

□ Thyroid disorder Who: _____ □ Cancer Who: _____

This information is kept strictly confidential. Do you: □ Use tobacco □ Drink alcohol □ Use recreational/illicit drugs □ None

Are you: □ Current Smoker □ Former Smoker □ Never Smoked

If yes, please give the type, frequency, amount, and duration (how long): _____

Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis

Patient (or parent) signature: _____ Date: _____

Doctor's Initials: _____ Date: _____