



Janet Corbit-Drakulich, O.D., M.Ed. • 2874 N. Carson Street, Suite 210 • Carson City, NV 89706 • 775.887.8866 • Fax 775.283.3245

## PATIENT HISTORY QUESTIONNAIRE

Date: \_\_\_\_\_ Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Parent Name (if applicable): \_\_\_\_\_

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, vision screenings, etc. Your email will not be shared with others and will be used responsibly).

Date of Birth: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M/F Marital Status: S/W/M/D

Emergency Contact & Telephone Number: \_\_\_\_\_

Name of person responsible for payment: \_\_\_\_\_

Name of vision coverage: \_\_\_\_\_

Name of insured: \_\_\_\_\_

**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/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 Distored Vision/Halos Blurred Vision Vision Loss  
 Double Vision Tired Eyes Eye Strain w/Computers Poor Night Vision Poor Depth Perception Low Reading Comprehension