PATIENT HISTORY QUESTIONNAIRE

Last Name: _____ First Name: _____ MI: _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ SSN: _____
Date of Birth: _____ Age: _____ Occupation: _____ Employer: _____
Emergency Contact Name: _____ Phone: _____
Date of last eye exam: _____ Purpose of today's visit: ___Routine Exam (no medical complaints)
Referred by _____ ___Contact Lenses
___Referral from another doctor
___Diabetic eye exam
___Specific problem with eyes or vision (describe below)
_____

Medical Information

What is your general health? _____
Do you have problems with any of these systems? (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 / Immunity	Yes / No
Respiratory	Yes / No	Integumentary (skin)	Yes / No	Headaches	Yes / No
High blood pressure	Yes / No	Eyes	Yes / No	Mental	Yes / No

If yes, please explain _____
Diabetes Yes / No Type: _____ Date of Diagnosis: _____
Allergic to medication? Yes / No Which? _____ Reactions: _____
Other health problems _____
Current medication(s) _____ Check if none ___
Have you had any operations? Yes / No Kind? _____ When? _____
Name of family doctor _____
Date of last visit _____ Date of last tetanus shot _____

Family History

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

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
Do you have macular degeneration? Yes / No Retinal Detachment? Yes / No Blurred Vision? Yes / No
Do you wear glasses? Yes / No Contact Lenses? Yes / No Type? _____
Additional Information _____

Payment is expected at time of service

How will payment be made? Cash ___ Check ___ Visa ___ MasterCard ___ Discover ___
Most insurance accepted. If under the age of 18, please have parent/guardian initial below:
I consent to the examination and treatment of my child _____
Patient Name _____ Guardian _____
Patient / Guardian Signature _____ Date _____

PRIVACY PRACTICE ACKNOWLEDGEMENT

A copy of Blairsville Eye Care's Notice of Privacy Practices is available at check in upon request. Please look over this document if you desire, and sign below that you have had an opportunity to review it. Copies are available if you would like a copy to take with you.

Patient / Guardian Signature_____ Date_____