2020 EyeCare Center Optometry

PATIENT HISTORY QUESTIONNAIRE No _____

Today's Date: _____/_____/_____

Last Name: _____ First Name: _____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Age: _____ Sex : Male / Female

Address: _____ City: _____ State: ____ Zip: _____

Telephone: (H) (_____) _____-_____ (Cell) (_____) _____-_____ (W) (_____) _____-_____

Email Address _____ Occupation/Employer: _____

Emergency Contact Name: _____ Relation: _____ Phone No: (_____) _____-_____

How would you like to be contacted (*Please Check One*) : Cellular / Home Phone ____ Email ____ Mail ____

Do you have any vision insurance? Y / N If yes, which insurance carrier? _____

Insurance Member's Name _____ Member ID/SSN _____

Insurance Member's Date of Birth _____/_____/_____ Policy/Group # _____

Employer _____

How did you hear about us? Yellow pages / Friend / Relative / Internet / Other _____

Primary reason for today's visit: _____

Retinal Photo ____, ***Dilation*** ____, and ***Visual Field Test*** ____ are strongly recommended by our doctors, (Please indicate Yes or No on each line next to the specific test.) Initial: _____

Date of your last eye exam: _____/_____/_____Was the dilation performed? Y / N When: _____

MEDICAL INFORMATION

What is your general health? _____

Name of Family Doctor: _____ Date of last physical exam: _____

Do you or your family have problems with any of these systems?

Eyes	Y / N	Gastrointestinal	Y / N	Nervous	Y / N
Ears/Nose/Throat	Y / N	Genitourinary	Y / N	Endocrine (Glands)	Y / N
Cardiovascular	Y / N	Musculoskeletal	Y / N	Blood/Lymph	Y / N
Respiratory	Y / N	Integumentary (Skin)	Y / N	Allergic/Immunologic	Y / N
Mental	Y / N	Thyroid	Y / N	Others: _____	

If answer 'yes' to any of the above, please explain: _____

Do you or your family have: High Blood Pressure? Y / N Relation: _____

Diabetes? Y / N Type: _____ Relation: _____ Date of diagnosis: _____

Please Answer All That Apply.

Do you have: Allergies? Y / N Allergic to what? _____ What happens? _____

Medication Allergy? Y / N What happens? _____

Headaches? Y / N Other health problems: _____

Current medication(s): _____

Have you had any operations? Y / N What kind? _____ When? _____

Do you use Cigarettes/Tobacco? Y / N Alcohol? Y / N Other Substance? _____

20/20 EyeCare Center Optometry

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EYE INFORMATION

Do you or your family have:
Eye infection, disease, injury, or surgery? Y / N Relation: _____
Explain: _____
Glaucoma? Y / N Relation: _____ Macular Degeneration? Y / N Relation: _____
Retinal Detachment? Y / N Relation: _____ Cataracts? Y / N Relation: _____
Other Eye Condition(s)? Y / N What kind? _____ Relation: _____

PERSONAL EYE INFORMATION

Do you currently wear glasses? Y / N Age of present glasses _____
Do you currently wear contact lenses? Y / N Brand of contact lenses: _____
Type of contact lenses worn (please circle):

Hard	Soft	Rigid Gas Permeable	Disposable	Daily wear
Extended wear	Astigmatism	Multi-Focal	Monovision	

Do you sleep with your contact lenses? Y / N (please circle)
How many hours per day or how many days do you continuously wear your contact lenses? _____
What lens care system (contact lens solution) do you use? _____
Have you ever had a reaction to eye drops or any lens cleaning solution? Y / N
Explain: _____
Do you work with a ***Computer / Tablet / Smart Phone***? (please circle) How many hours per day? ____
Please list your hobbies: _____

Are you interested in Lasik surgery? Y / N (please circle)

AUTHORIZATION

I, the undersigned, acknowledge that I have read and understand the Notice of Privacy Practices and Store Policy for the office. I hereby authorize the release of any medical/vision records or any other information necessary to process insurance claims and/or to other practitioners involved in my care. I also authorize payment by third party payers to 20/20 Eyecare Center, Optometry / Dr. Susan Chen for services provided and understand that I am responsible for payment of services not covered under my insurance plan, or in the event that only partial or no payment is received within 90 days of the initial submission of the claim.

_____	_____	_____
Patient Name (please print)	Signature	Date
_____	_____	_____
Parent/Guardian Name (please print)	Parent/Guardian Signature	Date