Patterson Eye Care

Welcome to our office. We appreciate your completing this medical history questionnaire.

Patient Information

Patient Name _____
Last Name

_____
First Name Middle Initial

Parent(s) Name (if Minor) _____

Address _____

City _____

State _____ Zip _____

Home Phone (___) _____ Cell Phone (___) _____

E-mail _____

SS# _____

Sex ☐ M ☐ F Age _____ Birth date _____

☐ Married ☐ Widowed ☐ Single
☐ Minor ☐ Divorced

Occupation _____

Patient Employer/School _____

Employer Phone (___) _____

Spouse's Name _____

Birth date _____ SS# _____

Spouse's Employer _____

How did you hear about us? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

ID # _____ Group# _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birth date _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

ID # _____ Group# _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Patterson Eye Care all insurance benefits. I am financially responsible for all charges whether or not they are paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named clinic may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Patient, Parent or Guardian

_____ _____
Date Relationship to Patient

Eye Health History

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Family Physician _____
Date of last eye exam _____

Do you wear glasses? ☐ Yes ☐ No
☐ All the time ☐ Occasionally ☐ TV
☐ Reading ☐ Driving

Are you interested in contacts? ☐ Yes ☐ No

Do you wear contacts? ☐ Yes ☐ No
Type _____ Hours/Day _____
Describe any problems you have with your Contacts _____

Blurred Vision-Distance	☐ Yes ☐ No	Floaters or Spots	☐ Yes ☐ No
Blurred Vision-Near	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Burning Eyes	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Itching Eyes	☐ Yes ☐ No
Color Vision	☐ Yes ☐ No	Light Sensitive	☐ Yes ☐ No
Crossed Eyes	☐ Yes ☐ No	Loss of Vision	☐ Yes ☐ No
Discharge from Eyes	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Night Vision Problems	☐ Yes ☐ No
Double Vision	☐ Yes ☐ No	Red Eyes	☐ Yes ☐ No
Dry Eyes	☐ Yes ☐ No	Seeing Halos	☐ Yes ☐ No
Eye Infection	☐ Yes ☐ No	Seeing Flashes	☐ Yes ☐ No
Eye Injury	☐ Yes ☐ No	Twitching Eyelid	☐ Yes ☐ No
Eye Strain	☐ Yes ☐ No	Watering Eyes	☐ Yes ☐ No

Over

Health History

Place a mark on "Yes" or "No" to indicate if you have had any of the following.

	Yourself	Details
Allergic/Immunologic (allergies, hay fever, hives, lupus, fibromyalgia, etc.)	☐ Yes ☐ No	
Cardiovascular (high blood pressure, heart or vascular disease, high cholesterol, stroke, etc.)	☐ Yes ☐ No	
General/Constitutional (current fever, unexplained weight loss or gain, unusual fatigue)	☐ Yes ☐ No	
Ear, Nose, Throat (hearing loss, chronic cough, dry mouth, sinus congestion, etc.)	☐ Yes ☐ No	
Endocrine (diabetes, thyroid disease, etc.)	☐ Yes ☐ No	
Gastrointestinal (stomach upset, ulcer, hernia, etc.)	☐ Yes ☐ No	
Genitourinary (genitals, kidney & bladder)	☐ Yes ☐ No	
Blood/Lymph system (bleeding, anemia, etc.)	☐ Yes ☐ No	
Skin (acne, rash, skin cancer, etc.)	☐ Yes ☐ No	
Musculoskeletal (muscle aches, joint pain, arthritis, rheumatoid arthritis)	☐ Yes ☐ No	
Neurological (headache, migraines, seizures, etc.)	☐ Yes ☐ No	
Psychiatric (anxiety, depression, insomnia, etc.)	☐ Yes ☐ No	
Respiratory (asthma, bronchitis, emphysema, etc.)	☐ Yes ☐ No	

Are you Pregnant? ☐ Yes ☐ No Tobacco use? ☐ Yes ☐ No Alcohol or substance abuse? ☐ Yes ☐ No

Family History (includes parent, grandparent, sibling)

Has any member of your immediate family had a history of these conditions?

Blindness	☐ Yes ☐ No	Retinal disease or detachment	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Macular degeneration	☐ Yes ☐ No
Cataract	☐ Yes ☐ No	Crossed eyes or lazy eye	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	High blood Pressure	☐ Yes ☐ No
Heart disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No		

Medications

List any medications you are currently taking, including eye drops:

_____

_____

_____

_____

Pharmacy Name_____

Allergies

List your allergies to medications or other substances:

_____

_____

_____

_____

_____

Acknowledgement of Receipt

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient name _____ Parent or Guardian (if minor) _____

Please Print Please Print

Patient Signature _____ Date _____