ADVANCED VISION CARE — PATIENT HISTORY QUESTIONNAIRE

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Please check one: ☐ New Patient ☐ Returning Patient Appt. Date: Day ________ Appt. Time: ________

IMPORTANT: This questionnaire is to be reviewed at each annual appointment. Please answer all questions.

Last name ____________________ First name ____________________ MI ________

Address ____________________ City ____________ State ________ Zip ________

Home phone (____) ____________ Cell phone (____) ____________ Work phone (____) ____________

Name of Vision Insurance ____________ Insured's ID # / SS # ____________ Name of Medical Insurance ____________

Date of last eye exam ____________ Pupils Dilated? Yes / No Reason for visit: ☐ Glasses ☐ Contact Lens ☐ Both

DOB ____________ Occupation ____________ Employer ____________

Emergency Contact Name ____________ Phone number (____) ____________

Today's date ________ Any secondary vision insurance? Y/N Flex card? Y/N Referred by ____________

Medical Information

How is your general health? ____________

Do you have problems with any of these systems? **(Please circle yes or no)** Cancer/kind? ________ Yes / No

Gastrointestinal	Yes / No	Neurological	Yes / No	Endocrine(diabetes,thyroid)	Yes / No
Ears/Nose/Throat	Yes / No	Urinary	Yes / No	Blood/lymph	Yes / No
Cardiovascular	Yes / No	Muscles/bones	Yes / No	Allergic/immunologic	Yes / No
Respiratory	Yes / No	Integumentary (skin)	Yes / No	Headaches	Yes / No
High blood pressure	Yes / No	Eyes	Yes / No	Mental	Yes / No

Please explain ____________

Diabetes Yes / No Type ____________ Date of diagnosis ____________

Allergies to medication? Yes / No Which? ____________ Reactions? ____________

Other health problems ____________

Current medication(s) ____________ Check if none ☐

Have you ever had any operations? Yes / No What kind? ____________ When? ____________

Name of family doctor ____________ Date of last visit ____________

Are you pregnant? Yes / No Are you nursing? Yes / No Do you smoke Yes/No Do you drink? Yes/ No

Family History

High blood pressure	Yes / No	Relation ________	Macular degeneration	Yes / No	Relation ________
Diabetes	Yes / No	Relation ________	Retinal detachment	Yes / No	Relation ________
Glaucoma	Yes / No	Relation ________	Cataracts	Yes / No	Relation ________

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 What kind ____________ Date ________

Do you have glaucoma?	Yes / No	Cataracts?	Yes / No	Dry eyes?	Yes / No
Macular degeneration?	Yes / No	Retinal detachment?	Yes / No	Blurred vision?	Yes / No
Do you wear glasses?	Yes / No	Uncomfortable glasses?	Yes / No	Corneal abrasion?	Yes / No
Eye infection?	Yes / No	Iritis/uveitis?	Yes / No	Lazy eye?	Yes / No
Glare? (daytime/nighttime)	Yes / No	Headaches?	Yes / No	Itchiness?	Yes / No
Burning?	Yes / No	Double vision?	Yes / No	Grittiness?	Yes / No
Tearing?	Yes / No	Trouble seeing at night?	Yes / No	Flash of light?	Yes / No
Sunlight sensitivity?	Yes / No	Crossed eye/eye turn?	Yes / No	Floater/spots?	Yes / No

***Turn page over to BACK (answer or/& sign only if applicable)**