eyecare
THE BOUTIQUE
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Total Eyecare With a Flair

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PATIENT HISTORY QUESTIONNAIRE

THE EYECARE BOUTIQUE

PATIENT INFORMATION

Full Name ____________________ Today's Date ________

Address ____________________

City ____________________ State ________ Zip ________

Home Phone ____________________ Work Phone ____________________

Cell Phone ____________________ Email ____________________

DOB ________ SS# ________ Occupation/Student Grade ________

If new, who may we thank for referring you to our office? ____________________

☐ Vision Insurance Provider: ____________________ ID # ________

☐ Medical Insurance Provider: ____________________ ID # ________

Subscriber Name ____________________ DOB ________

Subscriber Employer ____________________ Relationship to Patient ________

Address (if different from above) ____________________

City ____________________ State ________ Zip ________

PATIENT & FAMILY EYE HISTORY

	Patient		Family Member		Who?
Cataracts	Y ☐	N ☐	Y ☐	N ☐	________
Glaucoma	Y ☐	N ☐	Y ☐	N ☐	________
Macular Degeneration	Y ☐	N ☐	Y ☐	N ☐	________
Eye Injury/Surgery	Y ☐	N ☐	If yes, describe		________
Other ________	Y ☐	N ☐	Y ☐	N ☐	________

Do you have any other symptoms, questions, or concerns about the health of your eyes? ____________________

____

Date of last eye exam: ________ Date of last physical exam: ________

PATIENT & FAMILY MEDICAL HISTORY

	Patient		Family Member		Who?
Diabetes	Y ☐	N ☐	Y ☐	N ☐	________
High Blood Pressure	Y ☐	N ☐	Y ☐	N ☐	________
Cancer	Y ☐	N ☐	Y ☐	N ☐	________
Pregnant or Nursing	Y ☐	N ☐			

Check all areas where you have or have had noted conditions:

☐ Gastrointestinal	☐ Urinary	☐ Blood
☐ Ear/Nose/Throat	☐ Nervous System	☐ Allergies
☐ Cardiovascular	☐ Psychiatric	☐ Eyes
☐ Respiratory	☐ Endocrine	☐ Headaches
☐ Muscles/Bones	☐ Skin	☐ Other ________

Family Doctor ____________________ Phone ________

List all prescription and over-the-counter medications you are taking: ____________________

____

List any medications you are allergic to: ____________________

Alcohol Use? Y ☐ N ☐ ________ drinks per ☐ Day ☐ Week ☐ Month

Tobacco Use? Y ☐ N ☐ ________ pack(s)/day

Do you wear glasses? Y ☐ N ☐ Do you wear contact lenses? Y ☐ N ☐ Brand ________

Are you interested in laser vision corrective surgery? Y ☐ N ☐

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