

**Patient History Questionnaire**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  New Patient  Previous Patient

Salutation:  Mr.  Mrs.  Ms.  Miss  Dr. Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ I prefer to be called-\_\_\_\_\_  
(First) (M.I.) (Last)

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone/Cell ( ) \_\_\_\_\_ - \_\_\_\_\_ E-Mail \_\_\_\_\_

Do you prefer to receive calls at:  Home  Work  Either

Whom may we thank for referring you to our office? \_\_\_\_\_

**Responsible Party / Insurance**

Person responsible for Account/Payment?  Self  Other \_\_\_\_\_

Vision Insurance \_\_\_\_\_ Medical Insurance \_\_\_\_\_ Do you have Medicare  No  Yes

Primary Insured's Name  Self  Other \_\_\_\_\_ **Please present insurance card to front desk**

If other, complete the following: Relationship to Patient \_\_\_\_\_  
Insured's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_

**Authorization and Release (If using Insurance)**

\*I hereby authorize the release of any medical or other information necessary to process my insurance claim. I authorize payment of benefits directly to Eyes on the Mountain. I understand that I am responsible for any deductible, share of cost, or uncovered service.

Signature of patient / or guardian \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Health History**

Reason for today's exam \_\_\_\_\_ (Medical insurance will only cover if there is a medical reason for the exam such as loss of vision, headaches, eye pain, eye redness, eye itching or burning, glaucoma, cataracts, floaters, dry eyes, etc.)

Date of last exam \_\_\_\_\_ Name of Eye Doctor \_\_\_\_\_ Family Doctor \_\_\_\_\_

List any drug allergies \_\_\_\_\_

List any medications you take \_\_\_\_\_

List any eye surgeries you have had \_\_\_\_\_

Do you wear glasses?  No  Yes If yes, how old is your current pair of glasses? \_\_\_\_\_

Do you wear contact lenses?  No  Yes Are you interested in contact lenses today?  No  Yes

**Family History**

Please note any self or family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

CONDITION	NO	YES	RELATIONSHIP	CONDITION	NO	YES	RELATIONSHIP
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Social History**

For insurance purposes are you:  Student  Single  Married  Widowed

Occupation \_\_\_\_\_ Your Employer \_\_\_\_\_

Do you have visual difficulty when driving?  No  Yes; Please describe: \_\_\_\_\_

How many hours per day do you spend on the computer? \_\_\_\_\_ hours/day

Do you use tobacco?  No  Yes If yes, type / amount / how long: \_\_\_\_\_

Do you drink alcohol?  No  Yes If yes, type / amount / how long: \_\_\_\_\_

Certain insurance companies require us to ask if you use recreational drugs?  No  Yes

**PLEASE BE SURE TO COMPLETE BOTH SIDES OF FORM**

**REVIEW OF SYSTEMS:** Do you have a problem with...

<u>SYSTEM</u>	<u>NO</u>	<u>YES</u>	<u>SYSTEM</u>	<u>NO</u>	<u>YES</u>
<b>EYES</b>			<b>EARS, NOSE, MOUTH, THROAT</b>		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Hayfever	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision / Halos	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<b>RESPIRATORY</b>		
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<b>CARDIOVASCULAR</b>		
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing / Watering	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Glare / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Eye Infections	<input type="checkbox"/>	<input type="checkbox"/>	<b>GASTROINTESTINAL</b>		
Sties or Chalazions	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Flashes / Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
<b>CONSTITUTIONAL / GENERAL</b>			Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<b>GENITOURINARY</b>		
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Genitals	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
<b>INTEGUMENTARY / SKIN</b>			Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<b>MUSCULOSKELETAL</b>		
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
<b>ALLERGIC / IMMUNOLOGIC</b>			Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<b>HEMATOLOGIC / LYMPHATIC</b>		
Medicine Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
<b>NEUROLOGICAL</b>			Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<b>PSYCHIATRIC</b>		
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>
<b>ENDOCRINE</b>			Depression	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Compulsive Behavior	<input type="checkbox"/>	<input type="checkbox"/>
Other Glands	<input type="checkbox"/>	<input type="checkbox"/>			

\*Doctor's Notes and Initials

\*For Future Visits

	History Reviewed by Patient
	Date and Patient's Initials

**Dilation Today**

- Yes, I would like to be dilated today.
- I am unsure about being dilated today. I would like more information please.
- No, I would not like to be dilated today. I understand the importance of a dilated eye exam.

**HIPAA Acknowledgement**

I am aware that Eyes on the Mountain abides by the HIPAA privacy Policy thereby keeping my personal and medical information confidential.

Patient / Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_