Patient History Questionnaire

Last name_______________________ **First** name___________________ MI ______

Address (Street, City, State, Zip)____

Telephone (H)_______________(W)__________________(C)____________________

SSN_________-_________-_________ Date of Birth__________________________

Occupation______________________Employer______________________________

Email Address____

Emergency contact: ________________Telephone Number:______________________

Medical Insurance____________Vision Insurance__________Subscriber_____________

Patient's relation to subscriber: self spouse child other Today's date____________

I give permission for PVA to release medical information to: ___________________

Review of Systems

What is your general health?_______________ Are you pregnant/ nursing?__________

Height_______ Weight_______ Pharmacy_____________________________

Do you have any of the following medical conditions? (please circle all that apply)

Headaches	Allergies/Hay fever	Psoriasis/Rosacea	Sinus congestion
Diabetes	Migraines	Depression	Weight loss or gain
Stroke	Heart disease	Asthma	Kidney disease
Chronic cough	Emphysema	Bleeding disorder	Multiple Sclerosis
Thyroid disease	Cancer	High blood pressure	Lyme Disease
Fibromyalgia	Arthritis	High cholesterol	Anxiety
Lupus	Chronic bronchitis	Dry throat/mouth	Seizures

Allergies to Medications?________________________ What happens?_____________

Current medication(s)____

Have you had any major operations? Y/N What?_____________________ When?_________

Name of Primary Care Doctor_____________________ Date of last visit______________

Social History

Do you use cigarettes/tobacco?__________Alcohol?___________ Do you drive?_________

Are you a carrier of or infected with: Hepatitis HIV Gonorrhea/Syphilis None

Marital/Living status: Single Married Widowed Live alone Live with family/friends

Family History: Please mark all that apply, immediate family members only.

High blood pressure _______________ Macular degeneration ____________________

Diabetes ______________________ Retinal detachment ____________________

Glaucoma _____________Cataracts _______________Blindness_____________

Other eye condition(s) What kind?____________________________

(Please Turn Over)

Personal Eye Information

Last eye exam_____________ Where_____________________________

What problems are you currently having with your eyes? (Circle all that apply)

Blurred vision	Redness	Foreign body sensation
Distorted vision/halos	Burning	Sandy or gritty feeling
Loss of side vision	Itching	Chronic lid infection
Loss of central vision	Dryness	Glare/light sensitivity
Double vision	Tired eyes	Eye pain or soreness
Floating Spots	Watering excessively	Flashes of Light
Crusting on eyelashes	Mucous discharge	

Do you have any of the following eye conditions? (please circle all that apply)

Blindness	Diabetic Eye Disease	Macular Degeneration	Keratoconus
Strabismus	Retinal Detachment	Glaucoma	
Cataracts	Lazy eye	Retinal Disease	

Computer use? Y /N Hrs/day?________

Have you had any previous eye surgeries? Ocular Injuries? Y / N

When_____________ Where_________________?

Do you wear glasses Y / N for distance for reading for computer/desk work

Are you interested in buying new glasses today? Y/ N / Undecided

Do you wear contact lenses? Y / N **Type:** Spherical Toric Multifocal **Material:** Soft RGP

If yes, do you wear your contacts without trouble? Explain:

Explain any problems:

Assignment and Release

I authorize payment of benefits directly to Dr. Sara Kleiner-Goudey and Dr. Gina Reiners for services rendered. I also authorize release of any medical information that may be required in determination of such benefits.

I understand that some services may require prior approval of my primary care physician for coverage and that, if I do not obtain that approval, I am financially responsible for the services.

I understand that my insurance carrier may not cover some services and products and benefit information does not constitute approval of payment. Deductibles and fees not paid by my insurance carrier will be my responsibility.

I acknowledge that I received a copy of Drs. Kleiner-Goudey and Reiner's "Notice of Privacy Act, HIPAA" policy.

Signature________________________Date_____________________________

Whom may we thank for referring you?_______________________________________

Doctor's initials_____________