EyeCare About Vegas
Patient History Questionnaire

Date: ___________________

First Name: ________________________ MI: ______ Last Name: __________________________ Nickname: ____________

DOB: ______/______/_________ Sex: ☐ Male ☐ Female Marital Status: ______________________

Address: ___________________________________ Apt: _______ City: ________________ State/Zip Code: ______________

Home Phone: (____) ___________ Cell Phone: (____) __________ May we text you? ☐ Yes ☐ No

Work Phone: (____) ___________ E-mail: ____

How did you hear about us? ☐ Past patient ☐ Vision insurance ☐ Location (drove/walked by) ☐ Online ☐ Yellow Pages ☐ Friend/Family ☐ Other

Preferred Method of Communication: ☐ E-mail ☐ Telephone ☐ Postal mail

Occupation: _____________________________ Employment Status: ☐ Employed ☐ Unemployed

Employer/School: _______________________ ☐ Retired ☐ Student

Emergency Contact: ______________________ Relationship: _____________________ Phone: (____) ___________

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Native Hawaiian/Pacific Islander
- ☐ Decline to Answer

Preferred Language: _______________________________

Race:
- ☐ African-American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Native American/Alaskan
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other/Decline to Answer

Primary Vision Insurance:
Insurance: ____
Name: ____
Address: ____
City/State/Zip: ____
Phone: (____) _________ Date of Birth: ___/___/_____
SSN or Insurance ID: __________________________________
Employer: ____

Secondary Vision Insurance:
Insurance: ____
Name: ____
Address: ____
City/State/Zip: ____
Phone: (____) _________ Date of Birth: ___/___/_____
SSN or Insurance ID: __________________________________
Employer: ____

Vision History

History of any eye condition(s): ____

Please list all eye drops you use & how often: ____

Last Eye Exam: _______________________ Optometrist/Eye Doctor: ____

Do you currently wear glasses? ☐None ☐ Distance Only ☐ Computer Only ☐ Reading Only ☐ Bifocal/Trifocal ☐ Progressive (No-line bifocal/trifocal)

Do you wear contacts? ☐Yes ☐No If Yes: ☐ Soft or ☐ Gas Permeable

Contact Lens Brand: ____________________________________ How often do you replace your contacts? ____________

If you do NOT wear contacts are you interested in a trial fitting: ☐ Yes ☐ No

On average, how many hours per day do you use a computer? ___________

Are **you** currently experiencing any of the following?

☐Eyes feel dry ☐Floaters ☐Headaches ☐Eyes itch
☐Eyes strained/tired ☐Flashing lights ☐Double vision ☐Eyes burn
☐Eyes frequently red ☐Halos around lights ☐Blurred vision ☐Eyes water
☐Frequent styes ☐Bothered by light/sun ☐ Other: ________________________________

Please indicate if any of the following apply to you or a family member (Check all that apply):

Disease/Condition	Self	Family	Relationship (blood relatives only)
Cataracts	☐	☐	
Glaucoma	☐	☐	
Macular degeneration	☐	☐	
Retinal detachment	☐	☐	
Lazy eye (Amblyopia)	☐	☐	
Eye turn (Strabismus)	☐	☐	
Blindness	☐	☐	
Diabetes	☐	☐	
Heart disease	☐	☐	
Other:			

Medical History

Physician's Name: ____________________ Last Visit Date: _________ Medication Allergies: _________________________

List all current medications: ____

Please list all major surgeries and year performed: ____

Check ALL chronic (on-going) problem(s) that apply to you:

General Health:	**Ear/Nose/Throat**:	**Cardiovascular**:	**Respiratory**:	**Genital/Urinary**:
☐Rapid weight loss or gain ☐Fatigue ☐Trauma ☐Pregnant/Nursing	☐Seasonal allergies ☐Hearing impaired ☐Sinusitis	☐High blood pressure ☐High cholesterol ☐Heart attack ☐Vascular disease ☐Stroke	☐Asthma ☐Bronchitis ☐Emphysema ☐COPD	☐Kidney stones/disease ☐Frequent urination ☐STD/STI
Muscle/Skeletal:	**Skin**:	**Neurological**:	**Psychiatric**:	**Endocrine**:
☐Head/neck injury ☐Arthritis ☐Joint pain ☐Ankylosing Spondilitis	☐Eczema ☐Rosacea ☐Psoriasis ☐Skin cancer	☐Alzheimer's ☐Dementia ☐Multiple Sclerosis ☐Migraines ☐Seizures	☐Anxiety ☐Depression ☐Bi-Polar ☐Schizophrenia	☐Thyroid dysfunction ☐Hormone dysfunction
Blood/Lymph:	**Allergic/Immunologic**:	**Gastrointestinal**:	**Other(s)**:_________________________	
☐Anemia ☐Leukemia ☐Bleeding disorder	☐Rheumatoid Arthritis ☐Lupus ☐HIV/AIDS	☐Acid reflux ☐Crohn's ☐Ulcer ☐Irritable Bowel (IBS)	______________________________ ______________________________ ☐ **DENY ALL (Check if this applies)**	

Social:

Tobacco use: ☐ None ☐ Former smoker ☐ Current smoker: ______packs/day ☐ Chewing tobacco
Alcohol consumption: ☐ None ☐ Occasional ☐ _____drinks/day
Non-prescription drug use: _______________________
Height: __________ Weight: __________