20/20 Optical Center
12 North Jefferson
Marshall, MO 65340
(660) 886-5584
2020opticalcenter.net

PATIENT HISTORY QUESTIONNAIRE

Please sign and date one line at the bottom of the page at each visit to confirm any changes.

Last name_____ First name_____ MI_____ Sex : M / F Race_____
If Child, Parent's name_____
Address_____City_____ State_____ Zip _____
Work Phone(____)_____ Home Phone (____)_____ Soc. Sec. # _____
Cell Phone (____)_____ Email Address_____
Birthday _____ Occupation _____ Employer _____
Emergency contact name _____ Phone # (____)_____
Today's date _____ Referred by _____ Marital status_____

Personal Medical Information

What is your general health?_____
Do you have problems with any of these systems? (**Please circle if yes)**

Gastrointestinal	Nervous	Endocrine (glands)
Ears/Nose/Throat	Urinary	Blood/lymph
Cardiovascular	Muscles/ bones	Allergic
Respiratory	Integumentary (skin)	Headaches
High blood pressure	Eyes	Mental

Please explain_____
Diabetes? Yes/No Type_____ Date of diagnosis _____
Allergies to medication? Yes/No Which?_____ Reactions?_____
Other health problems_____
Current medication(s)_____
Have you had any operations? Yes/No Kind?_____
Name of family doctor_____ Date of last visit_____
Height_____ Weight_____ Blood pressure_____/_____ (if known)
Do you smoke? Yes/No

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 any eye injuries? Yes/No 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 Contact lenses? Yes/No Type?_____
Additional Information _____

Family Medical History

High blood Pressure Yes/No Relation_____ Diabetes Yes/No Relation_____
Macular degeneration Yes/No Relation_____ Cataracts Yes/No Relation_____
Retinal Detachment Yes/No Relation_____ Glaucoma Yes/No Relation_____

Please make any changes and sign and date one line below if the above information is correct.

Patient signature_____ Date_____
Patient signature_____ Date_____
Patient signature_____ Date_____
Patient signature_____ Date_____

Dr. Dr. Init. _____
Use Dr. Init. _____
Only Dr. Init. _____
Dr. Init. _____

Please fill out insurance information on the back of this page →