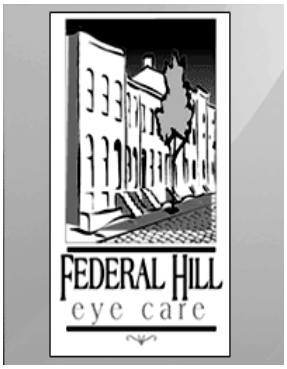
FEDERAL HILL EYE CARE

PATIENT HISTORY QUESTIONNAIRE



PATIENT NAME _____ **DATE** _____

DOB _____/_____/_____ **SOCIAL SEC #** _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____ **EMAIL** _____

OCCUPATION (GRADE IN SCHOOL) _____ **EMPLOYER (SCHOOL NAME)** _____

HOME PHONE NUMBER _____ **CELL PHONE NUMBER** _____

NAME OF SPOUSE (PARENT'S NAME IF CHILD) _____

FAMILY MEMBERS SEEN AT OUR PRACTICE _____

WHO CAN WE THANK FOR REFERRING YOU? (NAME) _____

☐ **ONLINE SEARCH ENGINE** ☐ **INSURANCE LISTING** ☐ **FAMILY MEMBER** ☐ **OTHER**

PUBLIC HEALTH REQUIRED INFORMATION

RACE: ☐ **CAUCASIAN** ☐ **AFRICAN AMERICAN** ☐ **ASIAN** ☐ **OTHER**

PREFERRED LANGUAGE: ☐ **ENGLISH** ☐ **SPANISH** ☐ **OTHER**

ETHNICITY: ☐ **HISPANIC/LATINO** ☐ **NON - HISPANIC/LATINO**

VISION INSURANCE _____ **MEDICAL INSURANCE** _____

SUBSCRIBER'S NAME _____ **SUBSCRIBER'S NAME** _____

SUBSCRIBER'S DOB _____/_____/_____ **SUBSCRIBER'S DOB** _____/_____/_____

PATIENT RELATIONSHIP TO INSURED (CHOOSE ONE)
☐ **SELF** ☐ **CHILD** ☐ **SPOUSE**

PATIENT RELATIONSHIP TO INSURED (CHOOSE ONE)
☐ **SELF** ☐ **CHILD** ☐ **SPOUSE**

SUBSCRIBER'S ID _____ **SUSBCRIBER'S ID** _____

PRIMARY CARE PHYSICIAN _____ **PCP PHONE NUMBER** _____

DATE OF LAST PHYSICAL _____ **DATE OF LAST EYE EXAM** _____

DO YOU USE TOBACCO PRODUCTS? ☐ **Y** ☐ **N** **DO YOU DRINK ALCOHOL?** ☐ **Y** ☐ **N**

DO YOU USE RECREATIONAL DRUGS ? ☐ **Y** ☐ **N** **WOMEN: PREGNANT/NURSING?** ☐ **Y** ☐ **N**

REASON FOR TODAY'S VISIT : ☐ **GLASSES** ☐ **CONTACTS**

☐ **MEDICAL CONCERN (PLEASE SPECIFY)** _____

☐ **OTHER VISION CONCERN (PLEASE SPECIFY)** _____

(PLEASE TURN OVER TO FILL OUT THE BACK OF THIS SHEET)

DO YOU OR A FAMILY MEMBER HAVE ANY OF THE FOLLOWING CONDITIONS ?

EYE HEALTH

GLAUCOMA	☐ SELF	☐ FAMILY	CATARACTS	☐ SELF	☐ FAMILY
MACULAR DEGENERATION	☐ SELF	☐ FAMILY	LAZY EYE / EYE TURN	☐ SELF	☐ FAMILY
DRY EYE	☐ SELF	☐ FAMILY	EYE ALLERGIES	☐ SELF	☐ FAMILY
FLASHES OF LIGHT	☐ SELF	☐ FAMILY	FLOATERS	☐ SELF	☐ FAMILY
EYE INJURY / INFECTION	☐ SELF	☐ FAMILY	EYE SURGERY	☐ SELF	☐ FAMILY

PLEASE LIST ANY PERSONAL EYE INJURY / INFECTION / SURGERY _____

PLEASE LIST ANY EYE DROPS YOU CURRENTLY USE _____

SYSTEMIC HEALTH

HIGH BLOOD PRESSURE	☐ SELF	☐ FAMILY	HIGH CHOLESTEROL	☐ SELF	☐ FAMILY
DIABETES	☐ SELF	☐ FAMILY	THYROID DISORDER	☐ SELF	☐ FAMILY
HEART DISEASE	☐ SELF	☐ FAMILY	CANCER	☐ SELF	☐ FAMILY
MIGRAINE HEADACHE	☐ SELF	☐ FAMILY	AUTOIMMUNE DISORDER	☐ SELF	☐ FAMILY
NEUROLOGICAL DISORDER	☐ SELF	☐ FAMILY	PSYCHIATRIC DISORDER	☐ SELF	☐ FAMILY

OTHER (PLEASE SPECIFY) _____

PLEASE LIST ANY MEDICATIONS YOU CURRENTLY TAKE _____

_____

_____

PLEASE LIST ANY MEDICATION ALLERGIES _____

COMPUTER USE : HRS PER DAY _____ ☐ STEADY USE ☐ ON AND OFF USE

DO YOU WEAR GLASSES? ☐ Y ☐ N ... IF YES, HOW OLD ARE THEY? _____

DO YOU WEAR SUNGLASSES? ☐ Y ☐ N ... IF YES, ARE THEY POLARIZED? ☐ Y ☐ N

ARE YOU BOTHERED BY GLARE AT NIGHT TIME? ☐ YES ☐ NO

ARE YOU BOTHERED BY GLARE IN THE OFFICE / WORKPLACE? ☐ YES ☐ NO

CONTACT LENS WEARERS : BRAND _____ HRS WORN PER DAY _____

HOW OFTEN DO YOU REPLACE YOUR CONTACTS? _____

WHAT TYPE OF SOLUTION DO YOU USE TO CLEAN & STORE YOUR CONTACTS? _____

PLEASE LIST ANY HOBBIES, ACTIVITIES, OR SPORTS YOU ENJOY _____

_____

PLEASE NOTE : INSURANCE MAY COVER PART OF YOUR CHARGES OR MAY BE PAYABLE DIRECTLY TO YOU. IN THE EVENT THAT YOUR INSURANCE DOES NOT COVER YOUR FULL EXPENSES, YOU WILL ULTIMATELY BE RESPONSIBLE FOR THESE CHARGES.

THANK YOU FOR FILLING OUT THIS FORM, WE ARE HAPPY YOU CHOSE OUR OFFICE FOR YOUR EYE CARE NEEDS.