Patient History Questionnaire

Date: _____

596 Ada Drive SE, Ada, MI 49301
616-676-1283 Fax: 616-676-9133
www.adavisioncare.com
info@adavisioncare.com

Personal Information

Full Name: _____ ☐ Male ☐ Female

Parent/Guardian (if patient is a minor): _____

Address: _____ DOB: _____

City, State, Zip: _____ SSN: _____

Email Address: _____ Home Phone: _____

Employer/School: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

Medical Doctor: _____ Last Medical Exam: _____

Address: _____ Doctor's Phone: _____

_____ Doctor's Fax: _____

Previous Eye Doctor: _____ Last Eye Exam: _____

Interests/Hobbies: _____

Whom may we thank for referring you to our office? _____
(Doctor – Another Patient – Insurance – etc.)

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Insurance Information

Medical Insurance: _____ ID #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____ Subscriber's SSN: _____

Subscriber's Employer: _____Relationship to Patient: _____

Vision Insurance: _____ ID #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____ Subscriber's SSN: _____

Subscriber's Employer: _____Relationship to Patient: _____

OCULAR HISTORY

Do you wear glasses? ☐ No ☐ Yes - Single Vision, Bifocal, Trifocal, Progressive (please circle which type)

If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ No ☐ Yes

If yes, what type? _____

Have you had refractive surgery? ☐ No ☐ Yes _____

Have you had any eye operations? ☐ No ☐ Yes _____

Have you had an eye injury? ☐ No ☐ Yes _____

Are you currently experiencing any of the following problems with your eyes? **Check the box if "Yes."**

☐ Blurred Vision	☐ Flashes/Floaters	☐ Redness
☐ Loss of Vision	☐ Halos/Glare/Light Sensitivity	☐ Excess Tearing/Watering
☐ Loss of Side Vision	☐ Dryness	☐ Eye Pain or Soreness
☐ Distorted Vision	☐ Sandy or Gritty Feeling	☐ Mucous Discharge
☐ Double Vision	☐ Burning	☐ Inflammation of the Eyelid
☐ Tired Eyes	☐ Itching	☐ Styes or Chalazion

Have you ever been diagnosed with any of the following ocular problems? **Check the box if "Yes."**

☐ Cataracts	☐ Glaucoma	☐ Retinal Detachment/Disease
☐ Crossed Eyes	☐ Lazy Eye / Amblyopia	☐ Dry Eye
☐ Diabetic Retinopathy	☐ Macular Degeneration	☐ Other _____

Social History

Do you use tobacco products? ☐No ☐ Yes If yes, type/how much/how often: _____

Do you drink alcohol? ☐No ☐ Yes If yes, type/how much/how often: _____

Do you use other substances? ☐No ☐ Yes If yes, type/how much/how often: _____

Please turn over and complete other side

MEDICAL HISTORY

Are you allergic to any medications? ☐ No ☐ Yes _____

List any medications you are currently taking (include eye drops, oral contraceptives, aspirin, over the counter medications and vitamins): _____

_____

List all major surgeries and/or hospitalizations you have had: _____

_____

Are you currently pregnant and/or nursing? ☐ No ☐ Yes

REVIEW OF SYSTEMS

Please check the box beside any problem you currently have, or have had, in the following areas:

Ears, Nose, Mouth Throat ☐ All Normal
- ☐ Allergy / Hay Fever
- ☐ Sinus Congestion
- ☐ Dry Throat / Mouth
- ☐ Chronic Cough
- ☐ Runny Nose
- ☐ Post-Nasal Drip

Cardiovascular / Cardiac ☐ All Normal
- ☐ Arteriosclerosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol

Constitutional ☐ All Normal
- ☐ Fever
- ☐ Weight Loss / Gain

Endocrine ☐ All Normal
- ☐ Diabetes, Type _____
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Cancer, Type _____

Gastrointestinal ☐ All Normal
- ☐ Diarrhea / Constipation
- ☐ IBS / Crohn's Disease
- ☐ Ulcers
- ☐ Reflux

Genitourinary ☐ All Normal
- ☐ Kidney Disease
- ☐ Cancer, Type _____

Hematologic / Lymphatic ☐ All Normal
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ HIV / AIDS
- ☐ Cancer, Type _____

Integumentary (Skin) ☐ All Normal
- ☐ Rashes
- ☐ Easy Bruising
- ☐ Cancer, Type _____

Musculoskeletal ☐ All Normal
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint Pain

Neurological ☐ All Normal
- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Seizures
- ☐ Stroke

Psychiatric ☐ All Normal
- ☐ Anxiety
- ☐ Depression
- ☐ Other

Respiratory ☐ All Normal
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ Lung Cancer

If you checked any of the above boxes or have a condition not listed, please explain further: _____

_____

_____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings) for the following conditions:

	Relation to You		Relation to You
☐ Glaucoma	_____	☐ Diabetes	_____
☐ Cataract	_____	☐ Cancer	_____
☐ Macular Degeneration	_____	☐ Heart Disease	_____
☐ Retinal Detachment	_____	☐ High Blood Pressure	_____
☐ Blindness	_____	☐ Lupus	_____
☐ Crossed Eyes	_____	☐ Kidney Disease	_____

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____