Patient History Questionnaire

Today's Date ___________________

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name _________________________________ First Name _____________________________ MI________
Address ___________________________ City ____________________________ State _______ Zip _________
Work Phone ____________________ Home Phone ______________________ **Cell Phone**___________________
Date of Birth _____________ Occupation ____________________________ Employer______________________
Emergency Contact Name ______________________________ Phone Number ___________________________

Date of Last Eye Exam ________________ Dilated? Yes/No Referred By _________________________________
Primary Vision Coverage (VSP, MES, Medicare, Superior, Vision, etc)____________________________________
Primary Member Social Security Number: __________________ Secondary Coverage______________________

E-Mail: ____ Texting: Yes/No

Medical Information

Do you take medications for any of these systems? **(Please circle Yes or No.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

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? ___________________________________ When? _____________
Name of family doctor and/or primary care physician ____
Date of last visit ___________________________ Date your blood pressure was last checked ________________

Family History

High blood pressure	Yes/No	Relation ____________	Macular degeneration	Yes/No	Relation ____________
Diabetes	Yes/No	Relation ___________	Retinal detachment	Yes/No	Relation ____________
Glaucoma	Yes/No	Relation ____________	Cataracts	Yes/No	Relation ____________

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 an eye injury? Yes/No Type ____ 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 ____

Social History

Tobacco use: Do you smoke? Yes/No If yes, how frequently? ____
Do you drink alcohol? Yes/No If yes, how frequently? ____

Do you use recreational drugs? Yes/No

Please checkmark ✓ those VISUAL TASKS that you do often:

☐ Deskwork	☐ Prolonged reading	☐ T.V
☐ Computer Work	☐ Golfing	☐ Movies
☐ Bookkeeping/ Accounting	☐ Driving / Biking	☐ Theatre
☐ Artwork / Craft	☐ Fishing	☐ Dining Out
☐ Typing	☐ Jogging / Walking	☐ Cards
☐ Sewing / Needlework	☐ Swimming / Beachgoing	☐ Shopping
☐ Cooking	☐ Skiing	☐ Dancing

Other VISUAL TASKS not listed ________________________________

Are you interested in contact lenses ☐ Yes ☐ No

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ____

Patient Phone Number: ________________________

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.
In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from Cerritos 2020 Optometry, A Professional Optometric Corporation

____ ________________

Signature or (Legal Guardian) **Date**

(If signing as a personal representative of the patient, describe relationship to the patient)

____ ________________

Relationship to Patient Print Name

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I've read and understood all information provided to me, including the Welcome sheet listing the policies for Cerritos 2020 Optometry. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status as well as any of the above information.

Your signature (or parent, if a minor) ______________________________ **Date** ______________