PATIENT HISTORY QUESTIONNAIRE

Last Name ___________________________ First Name _______________ Preferred Name _______________ Gender M / F

Address ____ City ______________________ State ____ Zip _____________

Phone: Home _________________________ Work___________________________ Cell ______________________________

SSN ____________--_________--______________ Date of Birth ________/________/____________ Age ______________

Preferred Language ___________________ Race ___________________________ Ethnicity ____________________________

Occupation ____ Employer ____

Married Y / N Spouse's Name ____

Emergency Contact Name and Phone Number ____

Medical Information

Medications and medical conditions can affect a person's eye health. Please provide the following medical information.

Are you being treated for: Diabetes Y/N Diabetic Retinitis Y/N Hypertension Y/N High-Cholesterol Y/N
Are you currently taking any medications? Y/N Please list them, and the conditions they are addressing, on the back of this form.
Do you have any Medication Allergies Y / N ____
Or any Other Allergies Y / N ____

Name of family doctor ____ Phone # ____________________________

For all patients age 13 and older we are now required to ask the following Social History questions.

Tobacco use? Never ____ Current Smoker _____ Smokeless Tobacco _____ Former - How long ago did you quit? _____

Alcohol use? Never ____ Social Use Only _____ 1-2/Day _____ Above Average ____ Alcohol Dependent ____

Narcotics use? No / Yes Blood Transfusions? No / Yes / HIV Positive STD? No / Yes / HIV Positive

Eye Health Specific Questions:

Do you wear glasses? Y/N Contact lenses? Y/N Type ____

Do you have: Glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Eye Pain? Y/N Eye Infection? Y/N

Do you have blurred vision? Distance Y/N Intermediate Y/N Near Y/N

Please explain any other eye problems ____

Have you had an eye injury? Y/N Kind ____ Date __________________

Have you had any eye operations? Y/N Type ____ Date __________________

Insurance Information

Do you have vision insurance? Y/N Name of plan or plans ____
Name of Insured ______________________________________ Patients Relationship to Insured __________________________
Insurance ID# _______________________ and SS# _______________________ Insured's Date of Birth ___________________

The HIPPA Act requires this office to obtain each patient's consent. My signature below constitutes my written consent for only Dr Anderson to use/disclose my health information only for his treatment, payment, healthcare insurance purposes and recall purposes. Signing below acknowledges that you have read and understand all of the terms above, and authorizes us to electronically file vision insurance claims using this signature as 'Signature on file for box 12 and 13 on CMS HICFA 1500 form'. Upon written request, this signature also authorizes us to send a Continuity of Care Report to another Physician.

Patient or Guardian MUST sign here ____ Today's Date _________________

Have you been previously seen by Dr Anderson within the last three calendar years? Y/N Last Exam Date ________________

Medications and medical conditions can affect a person's eye health.

Regarding patient ____ Date of Birth _____________________

The following is a list of all current medication and the conditions they are addressing, or, a separate list may be provided.

Current Medication(s) __________________________ Related Medical Condition ______________________________

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