MIDWEST EYE

Patient Questionnaire
Personal Information

Today's Date: _____

Name: _____ M/F Birth Date: ____/____/____ Social Security#: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Cell Phone: _____ Home Phone: _____

Employer: _____ Work Phone: _____ Date of Last Eye Exam: _____

Referred by ❑ Insurance ❑ Patient: _____ ❑ Other: _____

Responsible Billing Party (if other than patient): _____

Insurance Information: *Please bring in any and all medical and vision insurance cards and a valid government issued photo ID.*

The information and questions below are critical to the evaluation of your vision and health. Therefore, it is very important that every question be answered in detail. Your provided answers will remain confidential. Thank you.

Medical History

Do you have any allergies to medications? ❑ Yes ❑ No If yes, explain: _____

Do you have any other allergies? ❑ Yes ❑ No If yes, explain: _____

List any changes to medications you take (including oral contraceptives, aspirin, over the counter medications and vitamins):

Medication/Vitamin/Supplement	Dosage	Frequency

❑ Please see additional list *(Please provide copy of any additional medications)*

Who is your Primary Care Physician? _____ Phone: _____

Name of Pharmacy? _____ Address: _____ Phone: _____