MIDWEST EYE

Patient Questionnaire
Personal Information

Today's Date: _____

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

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Employer: _____ Last Eye Exam: _____

Referred by θ Insurance θ Patient: _____ θ Other: _____

Responsible Billing Party (if other than patient): _____

I understand that I am responsible for any balances not covered by insurance and agree to pay upon receipt of statement.

_____

Signature Date

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

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 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: _____

Circle any of the following that you have been diagnosed with:

crossed eyes lazy eye drooping eyelid prominent eyes eye infections eye injury

glaucoma retinal disease cataracts macular degeneration other:_____

Have you had cataract surgery? ❑ Yes ❑ No

If yes, when? Date(s): RT: _____ LT: _____ Surgeon: _____

List all other hospitalizations, surgeries and/or major injuries you have had:

Hospitalization/Surgery or Injury Type	Date

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

Do you have problems with glare? ❑ Yes ❑ No Do you have problems with night vision? ❑ Yes ❑ No

Do you use a computer? ❑ Yes ❑ No If yes, how many hours a day? _____

Do you wear glasses? ❑ Yes ❑ No If yes, how old is your present pair of glasses/lenses? _____

Do you wear contact lenses? ❑ Yes ❑ No Brand of contact lenses: RT eye: _____ LT eye: _____

Type of lenses: ❑ Soft ❑ RGP ❑ Hybrid ❑ Other Wearing schedule? ❑ Daily ❑ 2-week ❑ Monthly ❑ Other

Social History

This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.

❑ I would prefer to discuss my Social History information directly with my doctor. (Check box)

Occupation: _____ Sports/Hobbies: _____

Do you drive? ❑ Yes ❑ No
Do you have visual difficulty when driving? ❑ Yes ❑ No If yes, please describe: _____
Do you use tobacco products? ❑ Yes ❑ No If yes, type/frequency: _____
Do you drink alcohol? ❑ Yes ❑ No If yes, type/frequency: _____
Do you use illegal drugs? ❑ Yes ❑ No If yes, type/frequency _____
Are you pregnant and/or nursing? ❑ Yes ❑ No
Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

Review of Systems

Do you currently have any problems in the following areas:

SYSTEM	YES	NO	?
INTEGUMENTARY (SKIN)	❑	❑	❑
CONSTITUTIONAL			
Fever	❑	❑	❑
Weight Loss / Gain	❑	❑	❑
NEUROLOGICAL			
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
EYES			
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Distorted Vision/Halos	❑	❑	❑
Loss of Side Vision	❑	❑	❑
Double Vision	❑	❑	❑
Dryness	❑	❑	❑
Mucous Discharge	❑	❑	❑
Redness	❑	❑	❑
Sandy or Gritty Feeling	❑	❑	❑
Itching	❑	❑	❑
Burning	❑	❑	❑
Foreign Body Sensation	❑	❑	❑
Excessive Watering	❑	❑	❑
Glare/Light Sensitivity	❑	❑	❑
Eye Pain/Soreness	❑	❑	❑
Chronic Eye Infections	❑	❑	❑
Sties or Chalazion	❑	❑	❑
Flashes/Floaters in Vision	❑	❑	❑
Tired Eyes	❑	❑	❑
ENDOCRINE			
Thyroid/Other Glands	❑	❑	❑

	YES	NO	?
LYMPHATIC/HEMATOLOGIC			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
ALLERGIC/IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC	❑	❑	❑
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❑	❑	❑
Sinus Congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Post-Nasal Drip	❑	❑	❑
Chronic Cough	❑	❑	❑
Dry Throat/Mouth	❑	❑	❑
VASCULAR/CARDIOVASCULAR			
Diabetes	❑	❑	❑
Heart Pain	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular Disease	❑	❑	❑
GASTROINTESTINAL			
Diarrhea	❑	❑	❑
Constipation	❑	❑	❑
GENITOURINARY			
Genitals/Kidney/Bladder	❑	❑	❑
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑

Family History

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

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❑	❑	❑	_____
Cataract	❑	❑	❑	_____
Crossed Eyes	❑	❑	❑	_____
Glaucoma	❑	❑	❑	_____
Macular Degeneration	❑	❑	❑	_____
Retinal Detachment/Disease	❑	❑	❑	_____
Cancer	❑	❑	❑	_____
Diabetes Type 1 / Type 2 *(please circle)*	❑	❑	❑	_____
Heart Disease	❑	❑	❑	_____
High Blood Pressure	❑	❑	❑	_____
Kidney Disease	❑	❑	❑	_____
Lupus	❑	❑	❑	_____
Thyroid Disease *(please specify if known)*	❑	❑	❑	_____
Arthritis	❑	❑	❑	_____
Other	❑	❑	❑	_____