PATIENT QUESTIONNAIRE

Today's date: _____

Patient Name: _____ DOB: _____ SS# _____

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

Phone: Primary _____ Secondary _____ Work _____

Can we leave messages on your answering machine? _____ Contact you at work, if necessary? _____

Emergency Contact Name/Phone: _____

No Telephone? We can call to leave a message for you at (name/phone) _____

Email: _____ Referred by: _____

Employer/Retired from: _____ Occupation: _____

Gender: _____ Marital Status: S M D W Race: _____ Preferred Language: _____

Spouse Name: _____ Children's Names: _____

Parent/Guardian: _____ Women Are You: Pregnant? _____ Month? _____

Primary Care Physician: _____ Last seen: _____ Last eye exam: _____

Current medications: _____

_____

Allergies *(i.e. medications, seasonal, drops)* _____

_____

List major surgeries / injuries including eye: _____

_____

Your Medical History: Do you have or ever had any of the following? PLEASE CIRCLE

Eye Visual	Ear/Nose/Throat	Gastrointestinal	Skin	Psychiatric
Cataract	Sinusitis	Crohns D	Eczema	Depression
Glaucoma	Upper Resp Tract Infection	Colitis	Rosacea	Bi-Polar
Macular Degeneration	Other	Acid Reflux/Ulcer	Psoriasis	Schizophrenia
Retinal Detachment		Other	Other	ADD / ADHD
Eye Turn				

Cardiovascular	Endorcrine/Glands	Respiratory	Muscle/Skeletal	Genital/Urinary
High Cholesterol	Diabetes	Asthma	Arthritis	Urinary Tract
High Blood Pressure	Hormone Dysfunction	Bronchitis	Fibromyalgia	HIV +
Heart Disease	Thyroid Dysfunction	Emphysema	Ankylosing Sp	Herpes/Chlam
Stroke	Other	Other	Other	Other
Vascular Disease				

Hematologic/Lymph	Neurological	General Health	Allergic/Immunologic
Anemia	Multiple Sclerosis	Weight Loss/Gain	Lupus
Leukemia	Epilepsy	Headache	Rheumatoid Arthritis
Bleeding Disorder	Parkinsons	Fatigue	Environmental Allergies

TURN OVER TO COMPLETE

Social History: Tobacco Use: None Current User Previous Smoker
Alcohol Consumption: _____

Do you wear Glasses? Yes No Type: ___Single Vision, ___Bifocal, ___Progressive, ___Reading
Age of Present Glasses: _____
Do you Currently Wear Contact Lenses? Type? *(soft/hard)*_____ Brand?_____

Family Medical History: **Do any blood relatives have or have had any of the following conditions:**

Condition	Relationship (ie: mother, father, sibling, child, grandparent: maternal/paternal)
Cataract	
Glaucoma	
Macular Degeneration	
Retinal Detachment	
Eye Turn	
Diabetes	
High Blood Pressure	
Heart Disease	
Cancer	
Thyroid Disorder	
Arthritis	
Other	

Acknowledgement of Receipt of Contact Lens Agreement

My signature below verifies that I have received Thunder Bay Eye Care Contact Lens Agreement

Name of Patient *(print)*: _____ Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

My signature below verifies that I have been offered to read a copy of Thunder Bay Eye Care Privacy Practices

Name of Patient *(print)*: _____ Signature: _____ Date: _____
Signature of Patient Representative if Minor or unable to sign: _____
Relationship to Patient: _____

Yearly Acknowledgement:

Signature: _____ Date: _____
Signature: _____ Date: _____
Signature: _____ Date: _____