# PATIENT QUESTIONNAIRE FORM

**PATIENT INFORMATION**: (Please Print) Today’s Date\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Sex □ M □ F Married? ⧠ Yes ⧠ No Social Security # \_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Communication Preference: □ Mail □ Email □ Text □ Phone

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Eye Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Insurance (Medical)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Vision)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

Do you currently smoke? □ Yes □ No Former smoker? □ Yes □ N When did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently drink? ⧠ Yes ⧠ NO If yes, ⧠ Regularly ⧠ Socially ⧠ Rarely

Do you use recreational drugs? ⧠ Yes ⧠ No

**OCULAR HISTORY**

Are you currently experiencing any of the following?

Blurry vision. ⧠ Yes ⧠ No Eye Pain ⧠ Yes ⧠ No Itching ⧠ Yes ⧠ No

Discharge. ⧠ Yes ⧠ No Floaters ⧠ Yes ⧠ No Dryness/irritation ⧠ Yes ⧠ No

Double vision. ⧠ Yes ⧠ No Flashes ⧠ Yes ⧠ No Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you wear glasses? ⧠ Yes ⧠ No If yes, How old are your glasses\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear Contact lenses? ⧠ Yes ⧠ No What brand? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you sleep in your contacts? ⧠ Yes ⧠ No If yes, how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you change out your lenses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What solution do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all medication (prescription, over the counter or eye drops): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all ocular surgeries/ injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have allergies to medications: ⧠ Yes ⧠ No If yes, List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For women only:** Are you pregnant or nursing? ⧠ Yes ⧠ No

Have **YOU OR YOUR FAMILY** member been diagnosed with any of the following? Check the box

|  |  |  |
| --- | --- | --- |
| **Diagnosis** | **Self** | **Relative (parent, grandparents or siblings)** |
| Glaucoma |  |  |
| Macular degeneration |  |  |
| Corneal disease/ transplants |  |  |
| Retinal detachment |  |  |
| Lazy eye/ Strabismus |  |  |
| Dry Eye Syndrome |  |  |
| Cataracts |  |  |
| Diabetic retinopathy |  |  |
| Other: |  |  |

**MEDICAL HISTORY**

Have **YOU** been or currently experiencing any of the following symptoms:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Review of systems** | **Yes** | **NO** | **Diagnosis** | **List medication used to treat it** |
| Allergic (seasonal allergies, Hay fever) |  |  |  |  |
| Cardiovascular (HTN, high cholesterol, heart disease) |  |  |  |  |
| Constitutional (weight loss, fatigue) |  |  |  |  |
| Endocrine (diabetes, thyroid) |  |  |  |  |
| Gastrointestinal (Crohn’s disease) |  |  |  |  |
| Genitourinary (breast or prostate cancer, kidney stones) |  |  |  |  |
| Ear/Nose/Throat (sinusitis) |  |  |  |  |
| Neurological (migraines, frequent headaches, previous stroke) |  |  |  |  |
| Hematologic/Lymphatic (anemia, cancer) |  |  |  |  |
| Integumentary (skin/hair) |  |  |  |  |
| Musculoskeletal (arthritis, osteoarthritis) |  |  |  |  |
| Psychiatric (depression/anxiety) |  |  |  |  |
| Respiratory (asthma, COPD) |  |  |  |  |
| Immunologic (autoimmune disorder, HIV/AIDS) |  |  |  |  |

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**DILATION**

Dilation is an important part of a complete eye exam, where drops are used. The drops will make the pupils larger to allow the doctor to thoroughly examine inside the eyes for signs of disease or potential problems. Dilation usually wears off after 3-6 hours, depending on the person. You will have blurry vision at near and sensitivity to bright light during that time. Most people can see well at distance using sunglasses. Although most people can drive after dilation, we advised against driving after dilation especially if you don’t feel comfortable. If you choose to drive after dilation, you do so at your own risk and Apex Eye Care will in no way be held responsible. You may also choose to come back later to dilate or call someone to pick you up.

⧠ **YES**: I understand the importance and side effects of dilation and **I DO** grant permission for dilation

⧠ **NO**: I understand the importance of dilation; however, **I DO NOT** want to have my eyes dilated.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s/Guardian signature

**ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY**

I authorize Apex Eye Care or my insurance company to release any information needed to process my claims. I understand that I’m financially responsible for any co-pay, co-insurance, deductible, and other non-covered services at the day of services rendered. I also understand I’m responsible to obtain any referrals or pre-authorizations that is required by my insurance, prior to my visit and I’m financially responsible for any unpaid balance remaining after my claim has been processed. I understand that all unpaid accounts over 30 days past due will be subjected to outside collections agencies.

Patient/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

I acknowledge I have been offered or received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand the policy is subject to change depending on legislations. If changes are made, the practice will provide me a revised notice of privacy upon request.

Patient/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_