ENGLISH (REV012016)

PATIENT HISTORY QUESTIONNAIRE (Please Print)

TODAY'S DATE: _____

LAST NAME _____ FIRST NAME _____ MI _____ MALE / FEMALE

ADDRESS _____ CITY, STATE, ZIP CODE _____

TELEPHONE (H) _____ (W) _____ (C) _____

SSN _____ - _____ - _____ DATE OF BIRTH (MM/DD/YYYY) _____ / _____ / _____

(IF MINOR, GUARDIAN NAME _____ PHONE H | C | W _____ RELATION _____)

EMAIL(S) _____

OCCUPATION/EMPLOYER _____

WHO MAY WE THANK FOR REFERRING YOU? _____ NAME OF SPOUSE _____

INSURANCE INFORMATION

VISION INSURANCE(S) _____ HEALTH (MEDICAL) INSURANCE(S) _____

POLICY HOLDER'S NAME & DOB _____ RELATION TO PATIENT _____

POLICY HOLDER'S SSN _____ - _____ - _____ POLICY HOLDER'S EMPLOYER _____

EYE HISTORY

DATE OF LAST EYE EXAM _____ REASON FOR TODAY'S VISIT _____

DO YOU WEAR GLASSES? Y / N HOW MANY PAIRS DO YOU HAVE? 1 | 2 | 3 | 4 FOR: DISTANCE | READING | INTERMEDIATE | SUN

CONTACT LENSES? Y / N WHAT TYPE: SOFT | GAS PERMEABLE | TORIC | MULTIFOCAL BRAND _____ SOLUTION _____

ARE YOU TREATED BY AN OPHTHALMOLOGIST? Y / N IF SO, DOCTOR'S NAME _____ PHONE _____

HAVE YOU HAD ANY EYE SURGERIES AND/OR INJURIES? Y / N TYPE _____

DO YOU HAVE GLAUCOMA? Y / N CATARACTS? Y / N DRY EYES? Y / N BLURRED VISION? Y / N ITCHY EYES? Y / N

OTHER EYE PROBLEMS? Y / N WHAT KIND _____

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN _____ LAST VISIT _____ PHONE _____

PHARMACY OF PREFERENCE _____ PHONE _____ FAX _____

CURRENT MEDICATIONS _____

DO YOU HAVE ANY PROBLEMS WITH ANY OF THE FOLLOWING SYSTEMS? Please circle all that apply

Allergic/Immunologic	Y N	Ears/Nose/Throat	Y N	Genitourinary	Y N	Musculoskeletal	Y N
Blood/Lymph	Y N	Endocrine (glands)	Y N	Integumentary (skin)	Y N	Nervous	Y N
Cardiovascular	Y N	Gastrointestinal	Y N	Mental	Y N	Respiratory	Y N

DIABETES Y / N TYPE _____ DATE OF DIAGNOSIS _____

ALLERGIES Y / N TO WHAT? _____ MEDICATION ALLERGIES Y / N TO WHAT? _____

OTHER HEALTH PROBLEMS _____

HAVE YOU HAD ANY SURGERIES? Y / N IF SO, WHAT KIND _____

DO YOU SMOKE CIGARETTES / TOBACCO? Y / N DO YOU CONSUME ALCOHOL? Y / N DO YOU DRINK SOCIALLY? Y / N

FAMILY MEDICAL HISTORY

HIGH BLOOD PRESSURE	Y N	RELATION _____		MACULAR DEGENERATION	Y N	RELATION _____	
DIABETES	Y N	RELATION _____		RETINAL DETACHMENT	Y N	RELATION _____	
GLAUCOMA	Y N	RELATION _____		CATARACTS	Y N	RELATION _____	

OTHER EYE CONDITIONS NOT LISTED ABOVE _____

Payment Authorization --I authorize payment of all vision benefits for services and/or materials rendered directly to Suarez Optical as indicated. I understand that i am responsible for any payment not covered by the insurance plane and that services rendered and materials dispensed are not refundable. I also hereby authorize the release of information regarding my medical and vision history for the purpose of validating and determining benefits payable in the connection with the insurance claim. _____

Notice of Privacy Practices --I have had the opportunity to review Suarez Optical's notice of privacy practices.
I **DO** / **DO NOT** (please circle one) choose to have a copy of the notice of privacy practices. _____