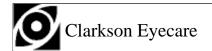


PATIENT HISTORY QUESTIONNAIRE (completion required at each patient appointment)



Title () Last name First name MI Date		
Name you wish to be called E-Mail		
Home Address		
Age Birthdate SSN Referred By		
Employer/SchoolOccupation (Please mark preferred) Cell		
Name of Parent, Legal Guardian or Spouse Home		
Name of family members whom we have provided care		
Insurance Company ID# Subscriber		
Subscriber name Relationship to patient Birthdate		
Race (Optional): Ethnicity (Optional):		
☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino		
□ Native Hawaiian or Other Pacific Islander □ White or Caucasion □ Not Hispanic or Latino		
Preferred Language:		
Medical History / Review of Systems: List any medications you are now taking (including eye drops, birth control pills, vitamins or over the counter medications):		
Are very allegain to any medications? Very No. Places list.		
Are you allergic to any medications? Yes No Please list:		
Primary Care Physician:Pediatrician:		
Preferred Pharmacy: Location: Phone:		
Do you have or have you ever had any of the following problems: ☐ No ☐ Yes Asthma/COPD ☐ Gastrointestinal Problems (ulcer, abdominal pain, diarrhea)		
	1)	
No Yes High Cholesterol No Yes Neurologic (numbness, weakness, headaches, strong problems No Yes Thyroid Problems No Yes Psychiatric Problems (depression, anxiety)	же)	
No Ves Chronic fever unexpected weight loss/gain fatigue (shortness of breath, wheezing)		
No Yes Ear/nose/throat (hearing loss, sinus) No Yes Seasonal Allergies □ No □ Yes Seasonal Allergies		
	·	
No ☐ Yes Endocrine Problems ☐ No ☐ Yes Skin Problems (rashes, excessive dryness, rosace	rine)	
No Yes Skin Problems (rashes, excessive dryness, rosace No Yes Urinary Problems (pain or discomfort, blood in u		
□ No □ Yes Urinary Problems (pain or discomfort, blood in u		
□NO □ Tes Endocrine Problems — —		
□ No □ Yes Urinary Problems (pain or discomfort, blood in u □ Pregnant/Nursing □ Other Condition/Illness □ List any previous major injuries/surgeries/hospitalizations:		
□ No □ Yes Urinary Problems (pain or discomfort, blood in u □ Pregnant/Nursing □ Other Condition/Illness □		
□ No □ Yes Urinary Problems (pain or discomfort, blood in u □ Pregnant/Nursing □ Other Condition/Illness □ List any previous major injuries/surgeries/hospitalizations: Eye History: Do you have or have you ever had any of the following problems:		
No ☐ Yes Urinary Problems (pain or discomfort, blood in u ☐ Pregnant/Nursing ☐ Other Condition/Illness ☐ List any previous major injuries/surgeries/hospitalizations: ☐ Eye History: Do you have or have you ever had any of the following problems: ☐ Blurred Vision ☐ Cataracts ☐ Double Vision ☐ Dry Eye ☐ Eye Injury ☐ Eye Surgery ☐ Flashes ☐ Floaters ☐ Gla		
No Yes Urinary Problems (pain or discomfort, blood in usually pregnant/Nursing Other Condition/Illness List any previous major injuries/surgeries/hospitalizations: Eye History: Do you have or have you ever had any of the following problems: Blurred Vision Cataracts Double Vision Dry Eye Eye Injury Eye Surgery Flashes Floaters Gla Lazy/Crossed Eye Loss of Vision Macular Degeneration Migraine/Headache Retinal Detachment Are you interested in correcting your vision with LASIK Surgery? Yes No		
No	ucoma	



PATIENT HISTORY QUESTIONNAIRE (completion required at each patient appointment)



Marital Status: Single Married Other Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No If yes, please describe:		
Smoking History		
Current Every Day Smoker		
Current Some Day Smoker	Do you drink alcohol?	
Former Smoker	Do you use illegal drugs? Yes No	
☐ Never Smoker	Have you ever been exposed to or infected with: HIV Hepatitis	
☐ Smoker (Current Status Unknown)	Thave you ever seem exposed to of infected with. If I is a life partial of the	
Unknown if ever smoked		
If patient is 18 or under, please complete:		
Any prenatal, perinatal, or postnatal problems	s?	
* *	No	
Do you have any concerns with your child's s	chool performance?	
Last eyecare provider:	Date of last eye exam	
Are you currently having eye or vision problems? [Yes No	
If yes, please explain		
Do you wear glasses? Yes No How old are the	hey? Are they bifocals?Yes No Are they forReadingDistanceBot	
Have you ever worn contact lenses? \square Yes \square No	If yes, when were they prescribed?	
-	why did you quit?es \sum \text{No If yes, please read the following information regarding contact lenses.}	
wearers require additional time and testing durin testing is only done for contact lens wearers, not	d even permanent vision loss if not cared for properly. New and existing contact lens g an eye examination to minimize the risk of serious eye problems. This additional for patients who do not wear contact lenses. For this reason, there are additional contact sting contact lens wearers. Your contact lens evaluation and services fee includes:	
 Specific curvature measurements of Evaluation of current and new lense 	f the corneas es to ensure optimal fit, vision and comfort	
	ear film and conjunctiva as they relate to contact lens wear	
4. Instructions regarding safe contact 1. 5. Contact lens follow up care for 90 c	lens wear, care and proper cleaning and solutions	
If you have any questions, please do not hesitate to speak	•	
Payment for all services and products is th	e responsibility of the patient.	
I agree to pay all copays, deductibles, co-i	nsurances and non-covered services as determined by my insurance company.	
I understand there is a returned check fee a	applied to every returned check.	
· · · · · · · · · · · · · · · · · · ·	for all accounts not paid in the time stated on the final monthly statement.	
	ion concerning my illness and treatment by Clarkson Eyecare to my insurance company.	
	medical information to any doctor whom I may be referred to.	
· · ·	ot a guarantee of payment as stated by my insurance company.	
I authorize payment of my insurance benefit	•	
	ns if Clarkson Eyecare is a participating provider for your plan.	
11 1	emized statement which you may submit to your insurance carrier. QUIRED AT TIME OF SERVICE	
Simple of the state of the stat		
Signature of patient or legal guardian	Today's Date	