DRIESEN EYE CENTER – Patient Questionnaire

Please complete all applicable information:

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth:_____ Social Security #:_____ Gender: M / F Marital Status:_____

Address:_____ City/State/Zip:_____

□ Home Phone:_____ □ Work Phone:_____ □ Cell:_____
(Please check which number is your preferred contact number)

Email: _____ (your email will not be released to any third parties)

Preferred Language: □ English □ Spanish □ Other:_____

Race/Ethnicity: □ White (non-Hispanic) □ Hispanic/Latino □ Black/African American □ Asian □ Native American □ Other

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Work/School Information

□ Employed □ Retired □ Full-time Student □ Part-time Student □ Unemployed

Occupation:_____ Employer:_____

If still a student: Grade:_____ School:_____

Household Information

Please complete information for the person responsible for payment (if other than self).

Name:_____ DOB:_____ SSN:_____ Employer:_____

Spouse:_____ DOB:_____ SSN:_____ Employer:_____

Address (if different than above):_____

Insurance Information
(Please present Insurance Cards & Claim forms prior to your exam)

Are you covered by: □ Medicare □ Title 19 (Medicaid) □ Vision Plan □ Medical Insurance

Does your medical insurance cover a routine eye exam? □ Yes □ No

*In some situations, your medical insurance will cover a portion of today's exam & we can submit a claim for you. All charges for refractive care, contact lens services, co-pays, and/or deductibles will be your responsibility.

Privacy Policy/Sharing of Information

- I authorize the Driesen Eye Center to submit and share information with third parties for purposes of insurance claim submission and referral for further care, as deemed necessary by my doctor. I authorize any holder of medical & vision information about me to release it to this office to assist with my vision care. I understand that all charges/deductibles not paid by my insurance are my responsibility and collections will occur on unpaid balances.
- I am aware of the Driesen Eye Center's HIPAA Privacy Policies.

Authorized Signature:_____ Date:_____

Who can we thank for referring you to our office?_____

DRIESEN EYE CENTER – MEDICAL HISTORY

Please complete all applicable information:

Vision/Eyewear History

What is your primary eyewear?: □ Contacts □ Full-time glasses □ Part-time glasses □ Readers □ None

How old is your current prescription:_____

Last Eye Exam:_____ By Whom?:_____

Contact Wearers:

What brand of lens are you wearing?:_____ Change lenses every _____ days / weeks / months

Ave number of hours worn per day:_____ Comfortable all day? □ Yes □ No

Do you currently have a pair of back up glasses? □ Yes □ No

Currently using any eye drops/artificial tears ? □ Yes □ No If yes, what:_____ How Often:_____

Any previous eye surgery?(Cataract/Retina/LASIK/Strabismus): □ Yes □ No Surgeon?_____

Please indicate if you (or a family member) have had any of the following eye disorders:

□ Cataracts □ Macular Degeneration □ Glaucoma □ Infection □ Injury □ Other_____

Medical History

Name of Family Physician:_____

Please indicate if you (or a family member) have had any of the following medical disorders:

□ High Blood Pressure □ Heart Disease □ Cancer □ Seasonal Allergies □ Arthritis □ Other:_____

Diabetic? □ No □ Yes: Meds:_____ Year of Onset:_____ Know your A1c ratio?:_____

Drug allegies? : □ None □ Yes:_____

List any medications you take, including oral contraceptives, non-prescription, & home remedies:

(**Or provide a list for us to copy**)

_____

_____

_____

_____

Social History

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

Do you drive? □ No □ Yes If yes, describe any visual difficulty you have when driving:_____

Do you use tobacco products? □ No □ Yes: How Often? _____/day (Smoking cessation information is available)

Alcohol Use: □ No □ Yes: How Often? _____ drinks/week Illegal Drug Use: □ No □ Yes

Have you ever been exposed to or infected with: □ Hepatitis □ TB □ HIV □ STD □ Other:_____

Had a flu shot this year? □ No □ Yes Up to date with immunizations? □ No □ Yes □ Unknown

(Please turn over and complete the second page)

Review of Systems

System	NO	YES
OVERALL HEALTH		
Fever, Weight Loss/Gain	☐	☐
SKIN		
Skin Disorders	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
EYES		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distortion/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dry Eye	☐	☐
Discharge	☐	☐
Redness	☐	☐
Sandy/Gritty Feeling	☐	☐
Itching/Burning	☐	☐
Watery Eyes/Tearing	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain/Soreness	☐	☐
Lid Mattering/Crusting	☐	☐
Stye/Chalazion	☐	☐
Flashes/Floaters	☐	☐
Tired Eyes	☐	☐
LYMPHATIC/BLOOD		
Anemia	☐	☐
ENDOCRINE		
Thyroid/Glandular	☐	☐

System	NO	YES
EARS, NOSE, THROAT		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose/Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
VASCULAR/CARDIOVASCULAR		
Diabetes	☐	☐
Chest Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Digestive Problems	☐	☐
URINARY TRACT		
Kidney Disorders	☐	☐
Urinary/Bladder	☐	☐
BONES/JOINT/MUSCLE		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
ALLERGIC/IMMUNOLOGIC		
Immune Compromised	☐	☐
PSYCHIATRIC		
Psychiatric Disorders	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

_____

Please describe any other vision or medical problems that you would like us to address today:

_____

_____

_____

_____