**DRIESEN EYE CENTER – Patient Questionnaire**

Please complete all applicable information: v2022.4

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial:\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M / F Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (only needed if used as your Vision Plan ID #)

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

**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 Policy Holder’s DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*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 unpaid balances will be turned over to a collection agency (additional collection fees will occur.
* Authorized to contact me by secure cellular, landline, or email regarding my records.
* I acknowledge that an electronic copy of my exam/prescription is available on the Patient Portal
* I am aware of the Driesen Eye Center’s HIPAA Privacy Policies.

Authorized Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 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

Last Eye Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By Whom:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

**Glaucoma:** Self Mother Father Sib **Retinal Detachment:** Self Mother Father Sib

**Cataract:** Self Mother Father Sib **Macular Degeneration:** Self Mother Father Sib

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**)

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# 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Review of Systems

**System** NO YES NO YES

OVERALL HEALTH EARS, NOSE, THROAT

Fever, Weight Loss/Gain Allergies/Hay Fever

SKIN Sinus Congestion Skin Disorders Runny Nose/Drip

NEUROLOGICAL Chronic Cough

Headaches Dry Throat/Mouth

Migraines RESPIRATORY

Seizures Asthma

EYES Chronic Bronchitis

Loss of Vision Emphysema

Blurred Vision VASCULAR/CARDIOVASCULAR Distortion/Halos Diabetes Loss of Side Vision Chest Pain Double Vision High Blood Pressure Dry Eye Vascular Disease Discharge GASTROINTESTINAL Redness Diarrhea Sandy/Gritty Feeling Digestive Problems Itching/Burning URINARY TRACT Watery Eyes/Tearing Kidney Disorders Glare/Light Sensitivity Urinary/Bladder Eye Pain/Soreness BONES/JOINT/MUSCLE Lid Mattering/Crusting Rheumatoid Arthritis Stye/Chalazion Muscle Pain Flashes/Floaters Joint Pain Tired Eyes ALLERGIC/IMMUNOLOGIC

LYMPHATIC/BLOOD Immune Compromised

Anemia PSYCHIATRIC

ENDOCRINE Psychiatric Disorders

Thyroid/Glandular

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

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

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