**Patient Information Questionnaire**

Today’s Date­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_Age\_\_\_\_\_\_

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Height\_\_\_\_\_\_\_\_\_\_\_Weight\_\_\_\_\_\_\_\_lbs

SSN\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_

Phone: Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred method of contact: Cell Home Work Email

Reason for today’s visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Who is your primary care physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Information**

Responsible Party\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party’s SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party’s Date of Birth\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

\_\_\_\_\_Private or Self Pay

Vision Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medical Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company/Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Lenses**

Do you wear contacts? \_\_\_\_\_\_\_\_\_If no, are you interested in trying contacts? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, what brand of contacts do you wear?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours a day?\_\_\_\_\_\_\_\_\_\_How many days a week?\_\_\_\_\_\_\_\_\_\_\_

How often do you sleep in them?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often to you replace them?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in Laser Corrective Surgery (LASIK)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear UV protection?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco?\_\_\_\_\_\_\_How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever used tobacco?\_\_\_\_\_\_\_\_\_\_

What kind, cigarettes, cigar, pipe, smokeless?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol?\_\_\_\_\_\_\_\_\_\_\_\_\_If yes, how much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much time do you spend on the computer a day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you participate in any sports? If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your hobbies?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Do you have any Allergies?\_\_\_\_\_\_If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications? If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Family includes parents, grandparents, siblings, and children

You Family

**Constitution**

□ □ Developmental

Disability

□ □ Cancer

□ □ Fatigue Syndrome

□ □ Weight Loss/Gain

□ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ear, Nose, Mouth &**

**Throat**

□ □ Hearing Loss

□ □ Sinusitis

□ □ Dry Mouth

□ □ Laryngitis

□ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neurological**

□ □ Multiple Sclerosis

□ □ Epilepsy

□ □ Cerebral Palsy

□ □ Tumor

□ □ Stroke/CVA

□ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatric**

□ □ Depression

□ □ Attention Deficit

□ □ Anxiety Disorder

□ □ Bipolar Disorder

□ □ Schizophrenia

­□ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular**

□ □ Hypertension

□ □ Stroke/CVA

□ □ Heart Disease

□ □ Vascular Disease

□ □ Congestive Heart

Failure

□ □ ­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You Family

**Respiratory**

□ □ Asthma

□ □ Bronchitis

□ □ Emphysema

□ □ COPD

□ □ Sleep Apnea

□ □ ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gastrointestinal**

□ □ Crohn’s Disease

□ □ Colitis

□ □ Ulcer

□ □ Acid Reflux

□ □ Celiac Disease

□ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Genitourinary**

□ □ Kidney Disease

□ □ Prostate Disease/Cancer

□ □ STD

□ □ Benign Prostate

Hypertrophy

□ □ Pregnant/Nursing

□ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Musculoskeletal**

□ □ Arthritis

□ □ Osteoarthritis

□ □ Fibromyalgia

□ □ Muscular Dystrophy

□ □ Ankylosing Spondylitis

□ □ Osteoporosis

□ □ Gout

□ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Integumentary**

□ □ Eczema

□ □ Rosacea

□ □ Psoriasis

□ □ Herpes Simplex/Cold

Sores

□ □ Herpes Zoster/Shingles

□ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You Family

**Endocrine**

□ □ Type 2 Diabetes

□ □ Type 1 Diabetes

□ □ Thyroid Dysfunction

□ □ Hormonal Dysfunction

□ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hematological/**

**Lymphatic**

□ □ Anemia

□ □ Large Volume Blood

Loss

□ □ High Cholesterol

□ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergic/Immune**

□ □ Rheumatoid Arthritis

□ □ Lupus

□ □ Sjogren’s Syndrome

□ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eyes**

□ □ Glaucoma

□ □ Glaucoma Suspect

□ □ Cataract

□ □ Age-related Macular

Degeneration

□ □ Surgery

□ □ Patching

□ □ Inflammatory Disorder

□ □ Strabismus

□ □ Amblyopia

□ □ Retinal

Hole/Detachment

□ □ Retinal Degeneration

□ □ Keratoconus

□ □ Injury

□ □ Dry Eye

□ □ Nystagmus

□ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_