Patient Health Questionnaire

Patient Information:

Full Name: ____ Date of Birth: ___/____/____

Address: ____

Preferred Phone #: ______________________ E-Mail Address: ____________________________

Primary Care Provider:_____________________ Patient's SSN: ____________________________

Employer or School: _______________________ Occupation or Grade: ______________________

Emergency Contact Name: ____

Emergency Contact Number: ____

How do you prefer to be contacted?

Home___ Cell ___ E-mail___

Gender: M / F

Lifestyle Information:

Please circle all that apply: Boating/Fishing Golfing Motorcycling Driving Hunting Swimming Woodworking Gardening Reading Hiking Participate in Sports Bicycling

Computer use (give hours/day____) Other:____

Due to current Federal Medical Guidelines, we are required to obtain the following information
Preferred Language English/Spanish **Race:** Black/African America, American Indian/Alaska Native, Hispanic, Asian, White, Native Hawaiian/ Other Pacific Islander **Ethnicity:** Hispanic/Latino, Native Hawaiian/Other Pacific Islander, Not Hispanic or Latino

Patient History:

What is the main reason for your visit today?____

Please list current medications: ____

____

List any allergic reactions to medications or eyedrops: ____________________________________

____

Women: Are you pregnant? Y/N

Please indicate if any of the conditions apply to you or a blood relative.

	Self	**Family**		**Self**	**Family**
Cataract	____	____	Eye Turn	____	____
Glaucoma	____	____	Macular Degeneration	____	____
Retinal Detachment	____	____	Eye Surgery	____	____
Eye Injury	____	____	Blindness	____	____

Other:____________________________

How did you choose our office? Please select all that apply

- Friend or Relative_________________________
- Internet Search (Google)
- Social Media
- Event: ________________________________

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Please indicate below (circle) if you have any of the following conditions:

Are you Diabetic: If so what year were you diagnosed? ______ What is your blood sugar today? ______

What is your current HbA1C?____

Current Smoker/Former Smoker/Non-Smoker Non-prescription drugs Alcohol Consumption: _________

Allergic/Immunologic
Lupus (SLE)
Rheumatoid Arthritis
Environmental Allergies
Seasonal Allergies

Ear, Nose and Throat
Sinusitis
Upper Respiratory
Tract Infection
Other

Gastrointestinal
Chrohn's Disease
Colitis
Acid Reflux/Ulcer
Other

Skin
Eczema
Rosacea
Psoriasis
Other

Psychiatrics
Depression
Bi-Polar
Schizophrenia
Other

Cardiovascular
High Blood Pressure
Heart Disease
Stroke
Vascular Disease
High Blood Cholesterol

Muscle/Skeletal
Arthritis
Fibromyalgia
Ankylosing Spondylitis
Other

Endocrine/Glands
Diabetes
Hormone Dysfunction
Thyroid Dysfunction
Other

General
Weight loss/gain
Fever
Fatigue
Other

Neurological
Multiple Sclerosis
Tremors
Epilepsy
Other

Respiratory
Asthma
Bronchitis
Emphysema
Other

Hematologic/Lymphatic
Anemia
Leukemia
Bleeding Disorder
Other

Genital/Urinary
Urinary Tract Infection
HIV Positive
Other

Servicing and Collections:
If we need to contact you to service your account or to collect amounts you owe, you authorize use (and our affiliates, agents and contractors) to contact you at any number you provide. Or at which we believe we can reach you. We may contact you in any way such as calling, texting or emailing. We may contact you using an automated dialer or pre-recorded messages. We may contact you on a mobile, wireless or similar device even if you are charged for it. If your account goes into collections, you will be required to pay the full balance of your account and an additional $36 collection fee.

Please Sign to acknowledge this form is current and that you received a copy of our Notice of Privacy Practices.

Patient Signature or legal guardian: __________________________________ Date: _________________

For office use

Eyeglass 1 Date:_______________
OD ___________________ **Add** ________________________ **Type:** _______________________
OS ___________________ **Add** _________________________ **Material:** ___________________
Trasitions/Polarized/Anti-Reflective/Teflon AR/ Tint

Eyeglass 2 Date:_______________
OD ___________________ **Add** ________________________ **Type:** _______________________
OS ___________________ **Add** _________________________ **Material:** ___________________
Trasitions/Polarized/Anti-Reflective/Teflon AR/ Tint

Contact lenses:
Brand: _______________________________ **OD** ____
BC: __________________________________ **OS** ____