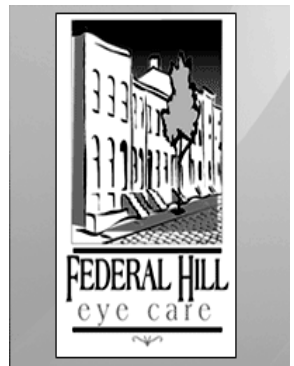


FEDERAL HILL EYE CARE

PATIENT HISTORY QUESTIONNAIRE



PATIENT NAME _____ DATE _____

DOB ____/____/____ SOCIAL SEC # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ EMAIL _____

OCCUPATION (GRADE IN SCHOOL) _____ EMPLOYER (SCHOOL NAME) _____

HOME PHONE NUMBER _____ CELL PHONE NUMBER _____

NAME OF SPOUSE (PARENT'S NAME IF CHILD) _____

FAMILY MEMBERS SEEN AT OUR PRACTICE _____

WHO CAN WE THANK FOR REFERRING YOU? (NAME) _____

ONLINE SEARCH ENGINE INSURANCE LISTING FAMILY MEMBER OTHER

PUBLIC HEALTH REQUIRED INFORMATION

RACE:	CAUCASIAN	AFRICAN AMERICAN	ASIAN	OTHER
PREFERRED LANGUAGE:	ENGLISH	SPANISH	OTHER	
ETHNICITY:	HISPANIC/LATINO	NON - HISPANIC/LATINO		

VISION INSURANCE _____ MEDICAL INSURANCE _____

SUBSCRIBER'S NAME _____ SUBSCRIBER'S NAME _____

SUBSCRIBER'S DOB ____/____/____ SUBSCRIBER'S DOB ____/____/____

PATIENT RELATIONSHIP TO INSURED (CHOOSE ONE) PATIENT RELATIONSHIP TO INSURED (CHOOSE ONE)
 SELF CHILD SPOUSE SELF CHILD SPOUSE

SUBSCRIBER'S ID _____ SUSBCRIBER'S ID _____

PRIMARY CARE PHYSICIAN _____ PCP PHONE NUMBER _____

DATE OF LAST PHYSICAL _____ DATE OF LAST EYE EXAM _____

DO YOU USE TOBACCO PRODUCTS? Y N DO YOU DRINK ALCOHOL? Y N

DO YOU USE RECREATIONAL DRUGS ? Y N WOMEN: PREGNANT/NURSING? Y N

REASON FOR TODAY'S VISIT :

GLASSES

CONTACTS

MEDICAL CONCERN (PLEASE SPECIFY) _____

OTHER VISION CONCERN (PLEASE SPECIFY) _____

DO YOU OR A FAMILY MEMBER HAVE ANY OF THE FOLLOWING CONDITIONS ?

EYE HEALTH

GLAUCOMA [] SELF [] FAMILY
MACULAR DEGENERATION [] SELF [] FAMILY
DRY EYE [] SELF [] FAMILY
FLASHES OF LIGHT [] SELF [] FAMILY
EYE INJURY / INFECTION [] SELF [] FAMILY

CATARACTS [] SELF [] FAMILY
LAZY EYE / EYE TURN [] SELF [] FAMILY
EYE ALLERGIES [] SELF [] FAMILY
FLOATERS [] SELF [] FAMILY
EYE SURGERY [] SELF [] FAMILY

PLEASE LIST ANY PERSONAL EYE INJURY / INFECTION / SURGERY _____

PLEASE LIST ANY EYE DROPS YOU CURRENTLY USE _____

SYSTEMIC HEALTH

HIGH BLOOD PRESSURE [] SELF [] FAMILY
DIABETES [] SELF [] FAMILY
HEART DISEASE [] SELF [] FAMILY
MIGRAINE HEADACHE [] SELF [] FAMILY
NEUROLOGICAL DISORDER [] SELF [] FAMILY
OTHER (PLEASE SPECIFY) _____

HIGH CHOLESTEROL [] SELF [] FAMILY
THYROID DISORDER [] SELF [] FAMILY
CANCER [] SELF [] FAMILY
AUTOIMMUNE DISORDER [] SELF [] FAMILY
PSYCHIATRIC DISORDER [] SELF [] FAMILY

PLEASE LIST ANY MEDICATIONS YOU CURRENTLY TAKE _____

PLEASE LIST ANY MEDICATION ALLERGIES _____

COMPUTER USE : HRS PER DAY _____ [] STEADY USE [] ON AND OFF USE

DO YOU WEAR GLASSES? [] Y [] N ... IF YES, HOW OLD ARE THEY? _____

DO YOU WEAR SUNGLASSES? [] Y [] N ... IF YES, ARE THEY POLARIZED? [] Y [] N

ARE YOU BOTHERED BY GLARE AT NIGHT TIME? [] YES [] NO

ARE YOU BOTHERED BY GLARE IN THE OFFICE / WORKPLACE? [] YES [] NO

CONTACT LENS WEARERS : BRAND _____ HRS WORN PER DAY _____

HOW OFTEN DO YOU REPLACE YOUR CONTACTS? _____

WHAT TYPE OF SOLUTION DO YOU USE TO CLEAN & STORE YOUR CONTACTS? _____

PLEASE LIST ANY HOBBIES, ACTIVITIES, OR SPORTS YOU ENJOY _____

PLEASE NOTE : INSURANCE MAY COVER PART OF YOUR CHARGES OR MAY BE PAYABLE DIRECTLY TO YOU. IN THE EVENT THAT YOUR INSURANCE DOES NOT COVER YOUR FULL EXPENSES, YOU WILL ULTIMATELY BE RESPONSIBLE FOR THESE CHARGES.

THANK YOU FOR FILLING OUT THIS FORM, WE ARE HAPPY YOU CHOSE OUR OFFICE FOR YOUR EYE CARE NEEDS.