PATIENT HISTORY QUESTIONNAIRE

PATIENT (Legal) LAST NAME ________________________ FIRST NAME_________________NICKNAME___________

MAILING ADDRESS______________________________________City, State, Zip Code___________________________

DATE OF BIRTH ____________E-Mail Address:___________________________(Optional) SS#_____________________

TELEPHONE(Home)__________________(Business)_______________ext._____(Cell)_________________Text ok?____
Ok to leave message? Y/N   Ok to leave message? Y/N   Ok to leave message? Y/N

EMPLOYER____OCCUPATION___________________________

MALE ___FEMALE___   (OPTIONAL) SINGLE ____ MARRIED ____ DIVORCED ____ WIDOWED ____

Preferred Language_______________________ Preferred Communication(Telephone,Postal,Email)______________________

(Optional)Race/Ethnicity:____

EMERGENCY CONTACT & TELEPHONE #____

GUARANTOR (if different from patient) NAME_________________________________ Date of Birth___________________

Relation to patient:____TELEPHONE_____________________________

MAILING ADDRESS____________________________________ CITY, STATE, ZIP CODE_________________________

PRIMARY/VISION INSURANCE NAME________________________________ ID #______________________________

SUBSCRIBER Name & Relation to patient:____ Date of Birth____________

SUBSCRIBER MAILING ADDRESS____ TELEPHONE________________

SECONDARY/MEDICAL INSURANCE NAME______________________________ ID #____________________________

SUBSCRIBER Name & Relation to patient:____ Date of Birth____________

SUBSCRIBER MAILING ADDRESS____ TELEPHONE________________

Please review and initial next to each of the following:

____ **Full payment is required at time of examination.**

____ **Payment of half down is required to *order* any materials.**

____ **Appointment cancellation policy- There will be a fee of $100 assessed for any appointments not cancelled 24 hours in advance and any no show appointments.**

______________   ____
Date   **Signature (Parent/Guardian if patient is a minor)**

DATE OF LAST EXAM__________________ DILATED?________ BY Dr.________________________

MEDICAL INFORMATION:

What is your general health?____

Do you have problems with any of these systems? (Please circle all that apply)

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/Lymph	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Allergic/Y/N Immunologic	

Please answer all that apply:

Diabetes Y/N Type:______________________________ Date of diagnosis______________

Allergies Y/N Allergic to what?______________________ What happens?______________

Medication allergy? Y/N What happens?______________________________ Headaches Y/N

Other health problems____

Current Medications____

____

Have you had any operations? Y/N Type?________________________ When?____________

Do you use cigarettes/tobacco?__________ Alcohol?__________ Other substance(s)?__________

Name of family doctor ______________________________ Telephone #______________

FAMILY HISTORY

High blood pressure Y/N Relation__________________ Macular degeneration Y/N Relation__________

Diabetes Y/N Relation__________________ Retinal detachment Y/N Relation__________

Glaucoma Y/N Relation__________________ Cataracts Y/N Relation__________

Other eye condition(s) ______________________________ Relation__________

PERSONAL EYE INFORMATION

Have you had any eye operations? Y/N type______________________________ Date__________

Have you had any eye injury?Y/N type______________________________ Date__________

Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred vision? Y/N

Other eye problems? Y/N What kind?____

Do you wear glasses? Y/N Contact lenses Y/N Type?________________________________

ACKNOWLEDGEMENT OF RECEIPT – NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of **Lori Ann K. Kim, O.D./Kenneth J. Fischer, O.D. Inc.**, Notice of Privacy Practices on (date)______________________________.

Patient Name (print):______________________________ Signature:______________________________

(Parent/Guardian if patient is a minor)