PATIENT HISTORY QUESTIONNAIRE

McPherson Optometry, P.C. 105 North Main Street, North Syracuse, NY 13212

Today's Date: / / .

Last Name First Name MI

Address City State Zip

Social Security # - - Date of Birth / / Age Sex M F

Home Phone Work Phone **Cell Phone**

May we contact you by email and/or text to your cell phone for appointments, office information, notification about your glasses or contact lenses, or our products? **Yes No**

If so, please list email: @ .

Employer Occupation Spouse/Partner

Parent/Guardian Name if minor

Last eye exam date / / Place Dilated Yes No

Referred by

Primary **Vision** Insurance Policy Holder Name

Policy Holder Social Security Number - - Policy Holder Date of Birth / /

Medical Insurance Policy Holder Name

Policy Holder Social Security Number - - Policy Holder Date of Birth / /

Policy Number

MEDICAL INFORMATION

What is your general health?

Do you have problems with any of these systems? Please check all that apply.

Asthma	Fibromyalgia	Muscle/Bones
Allergic/Immunologic	Gastrointestinal	Nervous System
Blood/Lymph	Headaches	Respiratory
Cardiovascular	High Blood Pressure	Skin
Ears/Nose/Throat	HIV/AIDS	Urinary
Thyroid	Mental Health	High Cholesterol

Diabetes Yes No Type Date of Diagnosis

Other health problems

Current Medications

Allergies to medications? Yes No Please list

Do you use: Tobacco? Alcohol? Other substances?

Have you had any operations? Yes No Please list

For women, are you pregnant? Yes No

Name of PCP-Primary Care Physician Last Visit? / /

Names of any specialists you see

FAMILY HISTORY

High Blood pressure Yes No Relation _____
Macular Degeneration Yes No Relation _____
Diabetes Yes No Relation _____
Retinal Detachment Yes No Relation _____
Glaucoma Yes No Relation _____
Cataracts Yes No Relation _____
Other Relation _____

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? Yes No _____
Please describe _____
Have you had any eye operations? Yes No Type _____ Date _____
Have you had any eye injuries? Yes No Kind _____ Date _____
Do you have:

Glaucoma Yes No
Macular degeneration Yes No
Floaters Yes No
Itchy eyes Yes No
Cataracts Yes No
Retinal detachment Yes No
Flashes of light Yes No
Red eyes Yes No
Dry Eyes Yes No
Blurred Vision Yes No
Pain in eyes Yes No
Discharge Yes No

Do you wear glasses? For what purpose? _____
Do you wear contact lenses? What brand? _____
What solutions do you use? _____
Are you having any problems with your contact lenses? _____
_____
Are you interested in contact lenses today? Yes No
Additional information: _____
_____

HIPPA RELEASE OF INFORMATION:

Please list up to 3 people with whom we have your permission to discuss your records. If you do not wish us to discuss your records with anyone, please write "NONE".

Name _____ relationship _____
Name _____ relationship _____
Name _____ relationship _____

Patient, please review, sign, and date on subsequent visits.

Signature _____ Date _____
Signature _____ Date _____
Signature _____ Date _____

Doctor Use Only

Reviewed by _____ Date _____
Reviewed by _____ Date _____
Reviewed by _____ Date _____
Reviewed by _____ Date _____