Patient Registration and History Questionnaire

MUST BE UPDATED AT EACH VISIT - PLEASE COMPLETE BOTH SIDES

Patient Name (Mr. Mrs. Ms Miss)________________________________ Date______________

Birthdate ____________ Patients SSN: ______________ Parent (if Child) ______________________

Address ________________________________ Home PH# ( ) ______________

City __________________ State________ Zip______ E-mail address: ______________

Employer ________________________________ Work PH # ( ) ______________

Occupation ________________________________ Do you work on a computer? Y / N. ____hr./day

Hobbies / Sports / Special Visual Demands: ________________________________

Date of Last Eye Exam________ Name of Last Eye Doctor________________ Phone # ( )__________

Date of Last Medical Exam ________ Name of Medical Doctor ________________ Phone # ( )________

Purpose of Today's Visit ________________________________

Whom may we thank for referring you? ________________________

Do you wear glasses? Y / N. If yes, for Distance / Near / Both How old are they? _____ Do you like wearing them? Y / N

Do you wear contact lenses? Y / N If Yes, what type of contact lenses are you wearing? Soft / Gas Permeable
Daily wear / Extended wear Disposable / Standard Astigmatism / Spherical Distance only / Monovision / Bifocal

If No, are you interested in contact lenses? Y / N If Yes: [ ] Full time wear [ ] Occasional wear
[ ] Bifocal / Monovision [ ] Astigmatic [ ] Tinted (to change/ enhance eye color) [ ] Sports [ ] Reduce/ Maintain Rx

How old are your contact lenses? _____ What solutions do you use? ________________________

Have you had refractive surgery? Y / N If No. are you interested in the procedure? Y/ N

Family Health History (please check all that apply and state which relative)

Cataracts____ Glaucoma____ Blindness____ Lazy/ Turned eye____ Macular Degeneration____ Retinal Detachment ____

Diabetes____ High Blood Pressure____ Heart Disease____ Arthritis____ Thyroid ____ Cancer____

Headaches / Migraines____ Other eve or health conditions: ________________________________

Insurance and Payment Authorization

Today's Professional fees will be paid for by: Cash / Check Credit Card Medicare Vision Insurance

Insurance Company:________________________________ ID#______________________

I request that payment of authorized insurance benefits be made on my behalf to the Buffalo Grove Eye Care Center. I authorize the release of information necessary to process claims. I permit my signature to be kept on file for future visits and insurance filings.

Due to the varying nature of vision and health insurance company plans, there may be additional fees or eligibility denials that my insurance dictates at the time of filing my insurance by the Buffalo Grove Eye Care Center. I understand and agree that regardless of my insurance benefits, I (or my guarantor) am responsible to pay for the balance on my account for all professional services and materials provided. I understand that if payment is not made in a timely manner, I may incur late or collection fees on all overdue balances on my account.

Signature________________________________ Date__________________

Patient Health History: Review of systems. Do you currently, or have you ever had problems in the following areas?

System	No	Yes	?
Constitutional			
Fever	____	____	____
Weight loss / gain	____	____	____
Cardiovascular			
Diabetes	____	____	____
High Blood Pressure	____	____	____
Vascular Disease	____	____	____
Heart Condition	____	____	____
Gastrointestinal			
Diarrhea	____	____	____
Constipation	____	____	____
Genitourinary			
Kidney	____	____	____
Bladder	____	____	____
Genitals	____	____	____
Neurological			
Headaches	____	____	____
Migraines	____	____	____
Seizures	____	____	____
Respiratory			
Asthma	____	____	____
Emphysema	____	____	____
Chronic Bronchitis	____	____	____
Hematological / Lymphatic			
Anemia	____	____	____
Bleeding problems	____	____	____
Ear, Nose, Mouth, Throat			
Allergies	____	____	____
Hay Fever	____	____	____
Sinus Congestion	____	____	____
Other________________	____	____	____
Bones / Joints / Muscles			
Rheumatoid Arthritis	____	____	____
Muscle pain	____	____	____
Joint pain	____	____	____
Allergic / Immunological	____	____	____
Psychiatric	____	____	____
Integumentary (skin)	____	____	____
Endocrine			
Thyroid / other glands	____	____	____

Have **you had any recent surgeries?** Y / N If Yes, please explain: ____

____

System	No	Yes	?
Eyes			
Blurred vision at near	____	____	____
Blurred vision at Distance	____	____	____
Glare / Light sensitivity	____	____	____
Temporary Loss of Vision	____	____	____
Loss of Side Vision	____	____	____
Distorted Vision / Haloes	____	____	____
Double Vision	____	____	____
Mucous discharge	____	____	____
Dryness	____	____	____
Redness	____	____	____
Foreign body sensation	____	____	____
Sandy or Gritty feeling	____	____	____
Itching	____	____	____
Burning	____	____	____
Excess Tearing / Watering	____	____	____
Eye pain or Soreness	____	____	____
Chronic Infection of Eye or Lid	____	____	____
Sties or Chalazions	____	____	____
Flashes of light	____	____	____
Floaters / Spots in vision	____	____	____
Tired Eyes	____	____	____
Previous Eye Surgery	____	____	____
History of patching an Eye	____	____	____
Eye Exercises / Vision Therapy	____	____	____

If you answered yes to any of the above, or have a condition not listed

please explain: ____

____

____

Pediatric Patients only:	No	Yes	?
Birth History Problems	____	____	____
Premature	____	____	____
Developmentally delayed	____	____	____
School age level appropriate	____	____	____

Please list all current medications: ____

Please list any drug allergies: ____

Social History: This information is kept strictly confidential.

Do you drive? Y N If Yes, do you have any visual difficulty when driving? Y N If Yes, Please explain: ____________________

____

Do you have any occupational concerns? Y N ____

Do you use Cigarettes / tobacco? Y N Do you use alcohol? Y N Do you use any other substances / recreational drugs? Y N

Have you been exposed to or infected with any infectious or immune diseases? Y N ____________________