PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

Last Name:______________________________ First Name:___________________________________ MI:_________

Address:____City, State, Zip:_____________________________

Primary Phone:_________________________________ Secondary Phone:___________________________________

Date of Birth:_____________________ Age_________Gender: Male / Female Marital Status: Married/Single/Other

SS#: ___________________________________Email: ____

Occupation:______________________ Employer:____

Emergency Contact Name: ____ Phone: _________________________

Reason for Today's Visit:____

Date of Last Eye Exam:______________ Dilated? Yes/No

How did you find out about us? ____

Insurance Information

Subscriber Name: ____________________________________ Relationship to Patient: _________________________

Date of Birth:____________________________ Subscriber SSN#:_____________________________________

Plan Name:_______________________Member ID:______________________________ Group ID: ________________

Questionnaire

Do you wear Contact Lens? ☐ Yes ☐ No If so, What type? ____

Are in interested in Contact Lens? ☐ Yes ☐ No If so, What type? ____

Are in interested in Refractive Surgery? ☐ Yes ☐ No

Patient Ocular History (Check all that applies)

☐ Wear Glasses	☐ Poor color vision	☐ Itching
☐ Blurred Vision	☐ Poor night vision	☐ Light sensitivity
☐ Glare problem	☐ Distorted vision	☐ Glaucoma
☐ Double vision	☐ Eye turn/lazy	☐ Cataracts
☐ Floater or spots	☐ Eye fatigue	☐ Macular degeneration
☐ Flashes of light	☐ Burning/sandy or gritty feeling	☐ Retinal detachment
☐ Eye pain or soreness	☐ Excess tearing/watering	☐ Eye Surgery (date: _____________)
☐ Loss of vision	☐ Redness	☐ Eye Injury (date: _____________)
☐ Loss of side vision	☐ Discharge	☐ Other:

General Health / Review of Systems

Do you have or take medications for any of these symptoms / problems? (Check all that applies)

☐ High blood pressure ☐ Heart condition/disease ☐ Diabetes

☐ Cholesterol ☐ Urinary: Kidney, Bladder ☐ Cancer: any type

☐ General: Weight loss/gain, Fever, Fatigue ☐ Skin: Rashes, eczema

☐ Ear/Nose/Throat: Hearing loss, Sinus , Chronic cough ☐ Endocrine: Thyroid

☐ Respiratory: Shortness of breath, wheezing, asthma, cough ☐ Digestive: Heartburn, diarrhea, reflux

Copyright by iVision Eyecare

☐ Neurological: Paralysis, numbness, seizures

☐ Blood: Anemia, sickle cell, excessive bleeding

☐ Psychiatric: Depression, anxiety, mental illness

☐ Bone/Joint/Muscles: Rheumatoid arthritis

☐ Are you taking any medication? ☐ Yes ☐ No If so, list them ____

____

☐ Any drug allergies? ____

☐ Do/Did you have any major illness/Injury? ____

☐ Any previous surgery? ____

Social History (Check all that applies)

☐ Do you drink alcohol?

☐ Do you smoke?

☐ Do you have history of drug abuse?

☐ Are you pregnant or nursing?

Family History (Check all that applies)

☐ High Blood Pressure, Relation____________________

☐ Diabetes, Relation______________________________

☐ Heart Disease, Relation_________________________

☐ Cancer, Relation_______________________________

☐ Retinal Detachment, Relation____________________

☐ Blindness, Relation_____________________________

☐ Cataracts, Relation_____________________________

☐ Glaucoma, Relation_____________________________

☐ Lazy Eye, Relation______________________________

☐ Macular degeneration, Relation__________________

A Dilated Fundus Exam enables us to provide a more thorough ocular health analysis. With the dilated pupils, we get a better view inside the eyes that allows us to detect early signs and changes of ocular pathologies. **A Dilated Fundus Exam is extremely essential for diabetics, hypertensives, high myopes, and/or any history of other related ocular diseases.** The side effects are blurred near vision and light sensitivity. In some individuals, the distance vision may also be blurred.

A Visual Field Analyzer is a highly computerized instrument that provides us a more thorough analysis of your fields of vision. Visual Field Screening can assist us in **early detection of glaucoma, retinal problems, and some neurological diseases** and **may diagnose causes of headaches**.

There is an **additional fee for visual field screening**. Please check the appropriate box below stating your preference.

❒ **I DO WANT THE DILATED FUNDUS EXAM** ❒ I do not want the Dilated Fundus Exam

❒ **I DO WANT THE VISUAL FIELD SCREENING** ❒ I do not want the Visual Field Screening

I understand that without these tests certain eye disease and conditions may not be discovered. I agree to assume all risks associated with refusing these tests, indemnify, hold harmless, and release iVision, its employees and optometrists, from any and all claims or liability whatsoever related to failure to diagnose and or treat any eye condition due to lack of diagnostic information which could have been obtained by these tests.

I acknowledge that I have received/read a copy of Dr. MaiAnh Tran's Notice of Privacy Practices.

ALL FEES PAID FOR PROFESSIONAL SERVICES ARE NON-REFUNDABLE AND PAYABLE AT THE TIME OF SERVICE.

____

Patient Signature (Legal Guardian if under 18 years old) Date

Copyright by iVision Eyecare