PATIENT HISTORY QUESTIONNAIRE

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

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____)_____ Cellular Phone: (____)_____ Work Phone: (____)_____

Date Of Birth: _____ Age: _____ ☐ Male ☐ Female Social Security #: _____-_____-_____

Your Occupation: _____ Employer: _____ Insurance Plan Name: _____

Policy Holder Info: Name_____ ID#_____ Date Of Birth _____

Emergency Contact Name: _____ Phone: (____)_____ Relation: _____

Email: _____

Medical Information

How is your general health? _____ Date Of Last Eye Exam: _____

Do you have problems with any of these systems? **(Please indicate yes or no.)**

Gastrointestinal	Yes No	Neurological	Yes No	Blood/Lymph	Yes No
Ear/Nose/Throat	Yes No	Urinary	Yes No	Allergic/Immunologic	Yes No
Cardiovascular	Yes No	Muscles/Bones	Yes No	Headaches	Yes No
Respiratory	Yes No	Dermatological (Skin)	Yes No	Diabetes	Yes No
High Blood Pressure	Yes No	Endocrine (Glands)	Yes No	Psychological	Yes No

List all allergies and/or other health issues not listed above:

_____

_____

If 'Yes' to Diabetes, Type: _____ Date of Diagnosis: _____

Current medication(s): _____

_____

Do you drive? Yes No Do you use tobacco products? Yes No Do you engage in recreational drug use? Yes No

Have you had any operations within the past 2 years? Yes No Kind? _____

Name of Family Doctor (PCP): _____ Date of last visit: _____

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: _____	Other Eye Disease	Yes No	Type: _____

Personal Eye Information

Do you have any eye conditions or problems? Yes No What kind?_____

Have you had any eye surgeries? Yes No Type: _____ Date: _____

Have you had laser vision correction? Yes No Are you interested in laser vision correction? Yes No

Have you had any eye injuries? Yes No Kind: _____ Date: _____

Do you have glaucoma? Yes No Cataracts? Yes No Macular Degeneration? Yes No Retinal Detachment? Yes No

Do you wear glasses? Yes No Sunglasses? Yes No Do you get blurred vision? Yes No If 'Yes', Near or Far

How many hours are you in the sun? _____ Do you work on a computer? Yes No How long are you on the computer? _____

Do you wear contact lenses? Yes No If 'Yes', What kind?: _____ If 'No', Would you like to? Yes No

Do you get dry, watery, or itchy eyes? Yes No When: _____

Do you use eye drops? Yes No What brand of drops?: _____

TO OUR PATIENTS

Sharper Vision is proud to offer our patients the latest technologies in eye care.

Visual Field testing quickly and accurately measures your central and peripheral vision, printing a map of the results. This aids in the detection of many ocular and systemic conditions (including glaucoma, cataracts, retinal detachments, eye and brain tumors, hemorrhages, M.S., diabetes, among other maladies), and establishes a baseline record of your unique visual field. This may later serve as a means for comparison, allowing earlier and more accurate diagnostic capabilities. This screening test takes only a few minutes, requiring you to look at a special computer screen and respond to a series of dim lights. It is not an x-ray, and there are absolutely no harmful effects. It is recommended that all patients ten and over take this test at their initial eye examination. There is a nominal fee of ONLY $15.00 to cover the cost of conducting this beneficial procedure.

Our high definition retinal camera allows us to capture color photographs of the back of each eye. These images are stored in our computer database and utilized in early pathology detection and future comparisons. Regular cost is $35 per eye, however, we are now offering to photograph both eyes for the total of **$39**

☐ Yes, I want the VF Test ☐ Yes, I want the Retinal Imaging

Authorized Signature Capture

Sharper Vision Eye Center and staff, are compliant in federally regulated HIPAA patient privacy laws. A copy of these regulations are available upon request.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. I understand that I am responsible for any payments due, should my insurance deductible not be met or be lapsed at the time of service.

Patient's Name: _____

Patient's or Authorized Person's Signature: _____

Date: _____