

PATIENT HISTORY QUESTIONNAIRE - NEW PATIENT

Name: Last _____ First _____ Middle _____ Nickname _____
Address _____ City _____ State _____ Zip _____
Phone (Home) _____ (Cell) _____ texting ok (Work) _____
Email _____
Preferred method of contact: Email, Phone call, Texting Date of Birth _____ Age _____
Social Sec. # _____ Employer _____
Male / Female _____ Race/Ethnicity _____ Height _____ Weight _____
Vision insurance? Yes / No _____ Medical insurance? Yes / No _____
Who is financially responsible for patient? Self Other (Please print) _____
Relationship: _____ Date of Birth _____

MEDICAL INFORMATION

Do you have any of these medical problems?

High blood pressure Yes / No Diabetes Yes / No -- Approx. Year Diagnosed _____
High Cholesterol Yes / No Cancer Yes / No

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

Respiratory(lung) Yes / No Gastrointestinal Yes / No Integumentary(skin) Yes / No
Cardiovascular(heart) Yes / No Nervous Yes / No Mental Yes / No
Ears/Nose/Throat Yes / No Genitourinary Yes / No Endocrine(thyroid) Yes / No
Blood/lymph Yes / No Musculoskeletal Yes / No
Other medical problems? _____

Please answer all that apply:

Please provide a list **OR** list medications: _____

Are you allergic to any medications? Yes / No _____
Do you use cigarettes/tobacco? _____ Alcohol? _____ Other? _____
Name of family doctor _____ Date of last visit _____
Are you pregnant? Yes / No

FAMILY HISTORY

(Father, Mother, Grandparent, Siblings)

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? _____

PERSONAL HISTORY

Do you wear corrective lenses? Yes / No **Glasses** **Contact lenses**
What is the reason for today's visit? _____

Do you have any of the following? (please circle all that apply)

Glaucoma? Yes / No Cataracts? Yes / No Dry Eyes? Yes / No Eye pain? Yes / No
Floaters? Yes / No Flashing lights? Yes / No Double vision? Yes / No
Have you had any eye operations? Yes / No Type _____ Date _____
Have you had any eye injury? Yes / No Kind _____ Date _____
Headaches? Yes / No please describe _____
Other eye problems? _____

Please turn over to complete, Thank you

Whom may we thank for referring you? _____ relation? _____

Please read and sign below. I authorize the release of any medical information necessary to process my insurance. I also authorize payment of medical benefits from my insurance to Dr. Nice for services rendered.

Signature _____ Date _____

Please read and sign below if the patient is a minor. As legal guardian, I authorize Dr. Nice and his staff to provide any necessary eye care in the examination and treatment of this patient.

Signature _____ Date _____

Relation to patient? _____

***Thank you for assisting us by completing this form.
We appreciate you visiting us today and look forward to serving you .***

Please present your insurance card to assist us in filing for your vision and medical benefits.