PATIENT HISTORY QUESTIONNAIRE - NEW PATIENT

Name: Last ____________________ First ____________________ Middle ___________ Prefers to be called: _______________

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 -- Type _________________ Resolved: 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: Your pharmacy's name & location:____________________________________

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

____

____

Are you allergic to any medications? Yes / No ____

Do you use cigarettes/tobacco? _____________________________ Alcohol? __________________ Other? ___________

Name of medical doctor ____

Name of doctor's office ____

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 nessesary 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.