PATIENT HISTORY QUESTIONNAIRE

Last Name ______________________ First name ______________________ MI _____ Date ______________

Date of Birth ______________ SSN ______________________ Email ______________________

Address ______________________ City ______________ State ________ Zip ______________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Employer ______________________ Occupation ______________________

Spouse Name ______________________ Date of Birth ______________ SSN ______________

Emergency Contact ______________________ Phone ______________

Purpose of today's visit: Routine Exam ❑ Contact Lens Exam ❑ Other ❑ ______________________

Do you currently wear : Glasses Y / N Sunglasses Y / N Occupational Glasses Y / N Contact Lenses Y / N

Date of last eye exam ______________ Dilated Y / N Referred By ______________________

IF MINOR

Father's Name ______________________ Date of Birth ________ SSN ____________ Employer ______________

Mother's Name ______________________ Date of Birth ________ SSN ____________ Employer ______________

MEDICAL INFORMATION

What is your general health? ____

High Cholesterol Y / N High Blood Pressure Y / N Headaches Y / N

Diabetes Y / N Type _______ Date of Diagnosis ______________ Family Doctor ______________________

Current Medications Y / N Please list ____

____

Allergies to Medication Y / N Name ______________________ What happens? ______________________

Have you had any operations? Y / N Type ______________________________ Date ______________

Eye Operations Y / N Type ______________________________ Date ______________

Eye Injuries Y / N Type ______________________________ Date ______________

Glaucoma Y / N Macular Degeneration Y / N Dry eyes Y / N

Cataracts Y / N Retinal Detachment Y / N Blurred vision Y / N

FAMILY HISTORY

High Blood Pressure Y / N Relation ______________ Diabetes Y / N Relation ______________

Macular Degeneration Y / N Relation ______________ Glaucoma Y / N Relation ______________

Retinal Detachment Y / N Relation ______________ Cataracts Y / N Relation ______________

HOBBIES

List ____

INSURANCE

Vision Y / N Member Name ______________________ ID# ______________ Date of Birth ______________

Medical Y / N Member Name ______________________ ID# ______________ Date of Birth ______________

Professional services are nonrefundable. Materials that qualify for return may be subject to a restocking fee. All returns must be made within 45 days of notification date with a valid receipt. Discounted packages and disposable contact lenses are neither returnable nor refundable. The above information is correct and accurate to the best of my knowledge. I authorize Drs. Manello, Reiss / Stein's Optical Clinic to bill my insurance. Any and all charges not covered by my insurance company will be my responsibility and will be paid upon receipt of statement.

Signature ______________________________ Date ______________ Doctor's Initials __________