PATIENT HISTORY QUESTIONNAIRE

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

Today's Date _____ Date of last exam _____

Last Name_____ First Name_____M.I._____DOB_____

Address_____City_____ St_____ Zip_____

Phone_____ Alt Phone_____ SS#_____ DL#_____

Employment Status ☐ Full-time ☐ Part-Time ☐ Retired ☐ Student Employer_____ Occupation_____

Marital Status ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐Single ☐Other _____

Email Address_____ Referred by_____

Smoking Status ☐ Never ☐ Former ☐ Occasional ☐ Daily | Start Date: _____Quit Date:_____ Packs per day:___

Medical Information

Do you have or have you had any of the following conditions / health issues? (Please circle yes or no)

Gastrointestinal	Yes / No	Nervous	Yes / No	Hormonal	Yes / No
Ears/Nose/Throat	Yes / No	Urinary	Yes / No	Blood/Lymph	Yes / No
Heart Attack/Stroke	Yes / No	Headaches	Yes / No	Arthritis/Joint	Yes / No
High Blood Pressure	Yes / No	Respiratory	Yes / No	Integumentary (skin)	Yes / No
Diabetes (Type_____)	Yes / No	Mental/Emotion	Yes / No	Allergic/Immunologic	Yes / No

Current medications and reason for use _____

Allergies to medication Yes / No Which?_____ Reactions?_____

Personal Eye Information

Have you had any eye operations? Yes / No Type_____ When?_____

Have you had any eye injuries? Yes / No Kind_____ When?_____

Do you have glaucoma?	Yes / No	Cataracts?	Yes/ No	Dry Eyes?	Yes / No
Macular Degeneration	Yes / No	Retinal Detachment?	Yes / No	Blurred Vision?	Yes / No

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

Do you wear glasses? Yes / No Contact lenses? Yes / No If yes, what type_____

Family History

High Blood Pressure	Yes / No	Relation_____	Diabetes	Yes / No	Relation_____
Heart Attack	Yes / No	Relation_____	Stroke	Yes / No	Relation_____
Retinal Detachment	Yes / No	Relation_____	Glaucoma	Yes / No	Relation_____
Macular Degeneration	Yes / No	Relation_____	Cataracts	Yes / No	Relation_____

Other Medical Conditions_____

Insurance Information

Insurance Name_____ Group#_____ Plan/Policy#_____

Insured's ID#_____ Insured's Name_____ Insured's DOB_____

Insured's SS#_____ Insured's Employer_____ Relationship to Insured_____

I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical, personal or insurance status. I understand that by signing this form I am allowing my information to be released upon my insurance company's request for purposes including, but not limited to, provider review, claims payment and quality assessment. I authorize payment of medical/vision benefits directly to Dr. Kennedy/Perspective Eyecare for services rendered. Non-covered expenses are due at the time of service. Perspective Eyecare will seek verification of vision eligibility prior to services rendered but I understand it is not a guarantee of payment by my insurance company*. I fully understand I am responsible for any amount not paid by my insurance and that this amount is due within 30 days of notification and that any outstanding balance after 30 days could be referred to a collection agency.* **I understand this office is HIPAA compliant and that I have the option of receiving a copy of its Notice of Privacy Practices.**

Signature_____ Date_____

Signature_____ Date_____

Signature_____ Date_____