

Insight Eye Care

Patient Medical History Questionnaire

Personal Information

Name: Preferred Name: Today's Date:
 Address: Phone:
 City: Work Phone:
 State: Zip: E-mail:
 Birth Date: Age: Social Security Number: Last Eye Exam:
 Occupation: Whom may we thank for referring you to our office?

Insurance Information

Medical Insurance (Primary): Name of Insured: DOB: SS#:
 Medical Insurance (Secondary): Name of Insured: DOB: SS#:
 Vision Insurance: Name of Insured: DOB: SS#:
 Please have cards ready for verification.

Medical History

List any known allergies to medications:
 List any medications you take. Please include ALL medications, including herbals and over-the-counter medications.

List all major surgeries, injuries and/or hospitalizations you have had:

Do you have, or have you had, any of the following? If so, when you were diagnosed or treated.

Crossed eyes	Lazy eye	Eye Infection
Drooping eyelids	Glaucoma	Eye Injury
Cataracts	Retinal hole/tear	Macular Degeneration
Are you pregnant or nursing?	Yes No	
Do you currently wear glasses?	Yes No	How old are they?
Do you wear contact lenses?	Yes No	How frequently do you replace them?
Type of lenses: Rigid Soft Other	Are they comfortable?	Yes No

Family History

Please note any family history of the following conditions:

<u>DISEASE / CONDITION</u>	NO	YES	?	<u>RELATIONSHIP TO YOU</u>
Blindness				
Cataract				
Crossed Eyes				
Glaucoma				
Macular Degeneration				
Retinal Detachment/Disease				
Arthritis				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Lupus				
Thyroid Disease				
Other:				

