NEVADA VISION GROUP
PATIENT HISTORY QUESTIONNAIRE

Today's Date__________________

Last Name______________________________ First Name__________________________ MI_________
What name would you like to be addressed by?____
Date of Birth____________________ SSN_________ - _________ - __________
Home Phone__________________ Cell Phone____________________Work Phone_________________
Best Number to be Reached_________________ Email Address__________________________________
Address____City____________ State______ Zip__________
Occupation________________________________ Employer____________________________________
Name of Parent/Spouse (circle one)____
Emergency Contact Name_______________________Relationship?__________ Phone _____________
Date of Last Eye Exam__________________ Dilated? Yes/No Doctor ____________________________
Primary Vision Coverage______________________ Secondary Coverage_________________________
Primary Medical Coverage_____________________ Secondary Coverage _________________________

Medical Information

What is your general health?____
Do you have problems with any of these systems? (**Please circle yes or no.**)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine(glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immune	Yes/No
Respiratory	Yes/No	Skin	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain ____
Diabetes Yes/No Type_________________ Do you take insulin?____ Date of diagnosis_________
Allergies to Medication? Yes/No Which?____________________ Reactions?___________________
Other health problems____
Current medication(s)____
Have you had any operations? Yes/No Kind?_______________________ When?__________________
Do you use cigarettes/tobacco? ___________________Alcohol consumption? ______________________
Name of family doctor ____
Date of last visit___________________________ Date of last tetanus shot__________________________

Family History

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___________

Personal Eye Information

Have you had any eye operations? Yes/No Type____
Have you had an eye injury? Yes/No Kind____
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 wear glasses? Yes/No Contact lenses? Yes/No Brand/Power _______________________
Whom may we thank for referring you? ____