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__________________ Birth State ________________ SSN_______ - ________ - _______
Primary Language___________ Race/Ethnicity_________/_________ Mother's Maiden Name________
Home Phone__________________ Work Phone__________________ Cell Phone_________________
Preferred Number (**circle one**) Home / Work / Cell Email Address________________________________
Address____________________________________ City____________ State_______ Zip___________
Occupation_______________________________ Employer____________________________________
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?____
Please note any conditions that apply (**Please circle yes or no.**)

Diabetes	Yes/No	High blood pressure	Yes/No	High cholesterol	Yes/No
If Diabetic: Type	I / II	Do you take insulin?	Yes/No	Year of diagnosis__________	

Do you have problems with any of these systems? (**Please circle yes or no.**)

Cardiovascular	Yes/No	Urinary	Yes/No	Psychiatric	Yes/No
Ears/Nose/Throat	Yes/No	Muscles/ Bones	Yes/No	Endocrine (Thyroid)	Yes/No
Respiratory	Yes/No	Skin	Yes/No	Blood/Lymph	Yes/No
Gastrointestinal	Yes/No	Nervous System	Yes/No	Allergic/Immune	Yes/No

Please explain any "yes" answers____
Allergies to medication? Yes/No Which?___________________ Reactions?_____________________
Other health problems____
Current medication(s)/vitamins____
____
Have you had any operations? Yes/No Kind?_____________________________ Year? ______________
Have you ever used cigarettes/tobacco? _______ Currently?_______ 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 _______________

*please note whether relation is "paternal" (P) or "maternal" (M) **(Ex. Maternal Grandmother = MGM)**

Personal Eye Information

Have you had any eye operations? Yes/No Type___________________________ Year?_______________
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 _____________________	

**Incomplete items will be assumed to be "negative".*