PATIENT HISTORY QUESTIONNAIRE

PLEASE PRINT CLEARLY

Date:

Last Name ______ First Name ______ MI ______

Address: ______ Apt. #______

City ______ State ______ Zip ______ E-Mail ______

Telephone (C) ______ (H) ______ (W) ______

SSN ______-______-______ Date of Birth ______ Sex Male Female

Occupation______ Employer ______

Emergency Contact / Phone ______

Insured Last Name ______ First ______

Address: ______ City ______ State ______ Zip ______

Insured SSN ______-______-______ Date of Birth ______ Employer ______

Insurance Plan ______ Policy Number /ID Number ______

Medical Information

What is your general health? ______

Do you have problems with any of these systems? (please circle all that apply)

Gastrointestinal	Y/N	Nervous	Y/N	Mental	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine (glands)	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/Lymph	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Allergic/immunologic	Y/N

Please explain ______

Please answer all that apply:

Diabetes Y/N Type ______ Date of Diagnosis ______ Allergies Y/N Allergic to what ______

Medication Allergy Y/N Allergic to what ______

Current Medication(s) ______

Other health problem? ______

Do you use cigarettes/tobacco? Y/N Alcohol? Y/N Other substance(s)? Y/N

Name of Family Doctor ______ Date of Last Visit? ______

Have you had any EYE operation? Y/N Type ______Date ______

Have you had any EYE injury? Y/N Kind ______Date ______

Do you have glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Blurred Vision? Y/N

Other EYE problems? Y/N What Kind? ______

Do you wear glasses? Y/N Do you wear Contact Lenses? Y/N Type ______

Additional information ______

Date of Last Exam ______ Dilated? ______

Who may we thank for referring you? ______

Family History

High Blood Pressure Y/N Relation ______ Macular Degeneration Y/N Relation ______

Diabetes Y/N Relation ______ Retinal Detachment Y/N Relation ______

Glaucoma Y/N Relation ______ Cataracts Y/N Relation ______

Other Eye Condition(s)? Y/N What Kind? ______

Acknowledgement of Receipt

I acknowledge that I received a copy of Dr. Connie Wang's Notice of Privacy Practices.

Patient Name (Please Print) ______

Signature ______ Date ______

Initials	Date