

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 |
|----------|------|
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