PATIENT HISTORY QUESTIONNAIRE

PLEASE PRINT CLEARLY

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