

**PATIENT HISTORY QUESTIONNAIRE**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ DoB \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_ S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Single  Married   
 Emergency Contact/Phone # \_\_\_\_\_ Name of last eye Dr. \_\_\_\_\_  
 Date of last eye exam \_\_\_\_\_ Dilated? \_\_\_\_\_ Referred by \_\_\_\_\_  
 How did you hear about our office? \_\_\_\_\_  
 Is anyone in your family a patient of Dr. Andren's? Yes  No  Who? \_\_\_\_\_  
 How many hours per day do you use a computer? \_\_\_\_\_ E-mail Address \_\_\_\_\_

**PERSONAL HEALTH HISTORY**

	Yes	No		Yes	No
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Head or spinal injuries .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, fainting .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Lupus .....	<input type="checkbox"/>	<input type="checkbox"/>
# Of years.....			HIV.....	<input type="checkbox"/>	<input type="checkbox"/>
Insulin .....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>
Migraines .....	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia .....	<input type="checkbox"/>	<input type="checkbox"/>
Depression .....	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>
Any nervous disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant .....	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer .....	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco/alcohol .....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	or other substance .....	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis .....	<input type="checkbox"/>	<input type="checkbox"/>	Other health problems .....	<input type="checkbox"/>	<input type="checkbox"/>

Please list all medications you are currently taking (including eye drops): \_\_\_\_\_

List any medications that you are allergic to: \_\_\_\_\_  
 Surgical History: \_\_\_\_\_ Family Physician: \_\_\_\_\_

**PERSONAL EYE INFORMATION**

	Yes	No		Yes	No		Yes	No
Cataracts .....	<input type="checkbox"/>	<input type="checkbox"/>	Corneal Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eyes.....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>	Retinal/macular Disease ..	<input type="checkbox"/>	<input type="checkbox"/>	Eye disorders ....	<input type="checkbox"/>	<input type="checkbox"/>

Do you wear: Eyeglasses? Yes  No  Contacts? Yes  No  (Soft/Hard)  
 Are you interested in wearing contact lenses? Yes  No  Did you have Lasik? Yes  No   
 Eye Surgery or Injuries: \_\_\_\_\_ Right \_\_\_\_\_ Left \_\_\_\_\_

**FAMILY HISTORY: Has anyone in your family (blood relative) had any of the following in the past?**

	Yes	No		Yes	No		Yes	No
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Corneal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Retinal/macular	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Retinitis Pigmentosa	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>
Other health problems	<input type="checkbox"/>	<input type="checkbox"/>	other eye problems	<input type="checkbox"/>	<input type="checkbox"/>	Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>

**CONSENT TO TREAT**

By signing this form, I consent to treatment for myself and/or on the behalf of the Minor for which this information pertains. I give my permission for the doctor to examine, diagnose and initiate treatment as deemed appropriate. I further attest that I am the Parent/Legal Guardian of the Minor and have the authority to authorize care or treatment. **SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_

Name of Vision Insurance Carrier \_\_\_\_\_  
 Insured Name & SS # \_\_\_\_\_

While Dr. Andren is happy to submit to my insurance for me, I understand I am responsible for all charges should my claim be denied. **SIGNATURE:** \_\_\_\_\_

**DOCTOR SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

