SPENCER EYE CARE

PATIENT HISTORY QUESTIONNAIRE

Today's Date: _____ Date of last exam: _____
Last Name: _____ First Name: _____ MI: ___ Date of Birth: _____
Address: _____
City: _____ State: ____ Zip: _____
Telephone: (H) _____ (C) asd _____ (W) _____
E-Mail: _____
Patient's Gender: M Patient's Occupation:_____ Patient's relationship to member: ⊙Self ○Spouse Dependent
Member's Name: _____ Member's ID#: _____
In case of an emergency, Name and Telephone: _____

MEDICAL INFORMATION

How is your general health? ○ Poor ○ Fair ○ Good ⊙ Excellent
Do you have any problems with the following: **(please circle Y for yes and N for no)**

Nervous N Headaches N Gastrointestinal N Ears/Nose/Throat N Allergic/Immunologic N
Mental N Urinary N Cardiovascular N Integument (skin) N Endocrine (glands) N
Cancer N Respiratory N Blood/Lymph N Muscle/Bones N High Blood Pressure N
Diabetes N Type: _____ Insulin N Pill Y Date of Diagnosis: _____
Allergies N To what? _____ Reaction: _____
Allergic to medication N Which? _____ Reaction: _____
If yes, please explain: _____
Other health problems: _____
Current medications: _____
Name and Telephone of Primary Doctor: _____
Date of last visit: _____ Date of last tetanus shot: _____

FAMILY MEDICAL HISTORY

Macular Degeneration N Relation to patient: _____ Diabetes N Relation to patient: _____
Retinal Detachment N Relation to patient: _____ Glaucoma N Relation to patient: _____
High Blood Pressure N Relation to patient: _____ Cataracts N Relation to patient: _____

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? N If yes, what kind? _____
Have you had any eye operations? N Type: _____
Have you had any eye injuries? N Type: _____
Glaucoma N Cataracts N Dry eyes N Blurred Vision N Macular Degeneration N Retinal Detachment N
Do you wear glasses? N Do you wear contact lenses? N If yes, what type/brand? _____
Reason for today's visit? _____
Who referred you to us? _____

ACKNOWLEDGEMENT OF RECEIPT

In accordance with HIPPA, I agree Spencer Eye Care has informed me of the Notice of the Privacy Practice.
Date: _____
Patient's Name: _____
Patient or Guardian Signature: _____

DOCTOR USE ONLY

Reviewed by: _____ Any changes N Date: _____
Reviewed by: _____ Any changes N Date: _____
Reviewed by: _____ Any changes N Date: _____