Welcome to Eap Optometry

CONFIDENTIAL

Please answer all questions on this patient questionnaire form. Date: _____

Last Name: _____ First Name: _____MI: _____

Date of Birth: _____ Gender: ❑ Male ❑ Female Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (H) _____ (W) _____ (C) _____

Vision Insurance: _____Medical Insurance: _____Referred By:_____

Primary Care Physician: _____ Primary Care Physician's Phone: _____

Occupation: _____ Last Eye Exam: _____ Last Physical Exam: _____

PERSONAL AND FAMILY MEDICAL AND EYE HISTORY

Do you or any member of your family have, or have had, any problems in the following areas? (Y = Yes, N = No)

	ME	FAMILY		ME	FAMILY
Diabetes:	❑Y ❑N	❑Y ❑N	Migraine:	❑Y ❑N	❑Y ❑N
High Blood Pressure:	❑Y ❑N	❑Y ❑N	Retinal Problems:	❑Y ❑N	❑Y ❑N
Heart Problems:	❑Y ❑N	❑Y ❑N	HIV or AIDS:	❑Y ❑N	❑Y ❑N
Cholesterol:	❑Y ❑N	❑Y ❑N	Allergies:	❑Y ❑N	❑Y ❑N
Cancer:	❑Y ❑N	❑Y ❑N	Lazy Eye:	❑Y ❑N	❑Y ❑N
Arthritis:	❑Y ❑N	❑Y ❑N	Glaucoma:	❑Y ❑N	❑Y ❑N
Thyroid:	❑Y ❑N	❑Y ❑N	Macular Degeneration:	❑Y ❑N	❑Y ❑N
Venereal Disease:	❑Y ❑N	❑Y ❑N	Cataracts:	❑Y ❑N	❑Y ❑N
Do you smoke?	❑Y ❑N		Are you pregnant?	❑Y ❑N	
History (HX) of Alcohol Abuse:	❑Y ❑N		HX of Substance Abuse:	❑Y ❑N	

Please list all medication(s) that you are currently taking: ❑None _____

_____

Please list allergies to all prescription, non-prescription medications and what happens: ❑None_____

_____

PERSONAL EYE HISTORY

Have you had any previous eye surgery? ❑Y ❑N If yes, which eye(s) and type: _____

Have you had any previous eye injuries? ❑Y ❑N If yes, which eye(s) and type: _____

If you had your eyes dilated before, did you have an adverse reaction to the dilating eye drops? ❑Y ❑N

Reason(s) for Today's Examination: _____

Do you currently wear eyeglasses? …… ❑Y ❑N If yes, for what distance(s): ❑Far ❑Close ❑Far and Close

Do you currently wear contact lenses? ❑Y ❑N If yes, please check all that apply below and list solution(s) used:

- ❑Soft ❑Rigid Gas-Permeable ❑Disposable ❑Astigmatism ❑Bifocal ❑Overnight
- Solution(s) Used: _____

ATTESTATION

I have read and understand, to the best of my knowledge, the above information. I certify that all statements are truthful and accurate. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I understand that I am financially responsible for any service considered non-covered, any deductibles and/or co-payments as well as any service denied due to non-participating provider. If my account becomes delinquent and is referred to an attorney or collection agency for collections, then I agree to pay a 30% attorney or collection fee on the unpaid balance.

_____ _____

Patient's or Parent's or Guardian's Signature Date

CERTIFICATION: ATTENDING OPTOMETRIST HAS REVIEWED THE ABOVE MEDICAL/EYE HISTORY

Attending Optometrist's Signature: _____

ATTESTATION: THERE IS NO CHANGE IN MY MEDICAL/EYE INFORMATION SINCE MY LAST VISIT

Signature: _____ *Date:* _____ *Signature:* _____ *Date:* _____