PATIENT QUESTIONAIRE

LAST NAME_____ FIRST NAME_____ MI_____
ADDRESS_____APT#_____CITY_____ ZIP_____
TELEPHONE (H)_____(C)_____(W)_____
DATE OF BIRTH_____SOCIAL SECURITY NUMBER_____
GENDER: __FEMALE __MALE E-Mail Address_____
INSURANCE COMPANY_____ ID#_____
POLICY HOLDERS NAME_____ DOB_____

MEDICAL INFORMATION

DO YOU HAVE PROBLEMS WITH THE FOLLOWING

EAR, NOSE, MOUTH, OR THROAT	Y/N	THYROID, OTHER GLANDS	Y/N
ASTHMA, CHRONIC BRONCHITIS	Y/N	PHYCHIATRIC/MENTAL	Y/N
EMPHYSEMA	Y/N	HEADACHES, MIGRAINES	Y/N
CHOLESTEROL	Y/N	SEIZURE	Y/N
HEART/VASCULAR DIEASE	Y/N	FEVER	Y/N
HIGH BLOOD PRESSURE	Y/N	SKIN PROBLEMS	Y/N
KIDNEY, BLADDER, GENITALS	Y/N	ALLERGIES	Y/N
ANEMIA, BLEEDING PROBLEM	Y/N		
DIABETES	Y/N		

ALLERGIC TO MEDICATION_____
LIST ALL CURRENT MEDICATION_____
LIST ALL MAJOR INJURY/SURGERY YOU HAVE HAD_____
DO YOU SMOKE CIGARETTES/TOBACCO? Y/N ALCOHOL Y/N ILLEGAL DRUGS Y/N
HAVE YOU EVER BEEN EXPOSED/INFECTED WITH: GONORRHEA_HEPATITIS_HIV_SYPHILIS
NAME & PHONE# OF FAMILY DOCTOR_____DATE OF LAST VISIT_____

PERSONAL EYE HISTORY

DO YOU HAVE :

GLAUCOMA Y/N	CATARACT Y/N	BLURRED VISION Y/N	DOUBLE VISION Y/N
DRY EYES Y/N	REDNESS Y/N	BURNING Y/N	ITCHING Y/N
TEARING Y/N	EYE PAIN Y/N	FLASHES/FLOATERS Y/N	LIGHT SENSITIVE Y/N

FAMILY HISTORY

HIGH BLOOD PRESSURE	Y/N	MACULAR DEGENERATION	Y/N
DIABETES	Y/N	RETINAL DETACHMENT	Y/N
GLAUCOMA	Y/N	CATARACT	Y/N

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED, CERTIFY THAT MY INSURANCE COVERAGE IS WITH_____AND ASSIGN DIRECTLY TO **TRUWAY VISION CARE** ALL INSURANCE BENEFITS FOR THE SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE **TRUWAY VISION CARE** TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

RESPONSIBLE PARTY SIGNATURE_____DATE_____