John P. Skrobot, O.D. **Patient Questionnaire**

General Information

Dr., Mr., Mrs., Ms. _____ Birth date _____
Last First Middle

Whom may we thank for referring you to our offices? _____

Guardian's name, if patient is a minor _____

Person responsible for account _____

Residence address _____
Number Street

_____ Phone _____
City State Zip Area Code

Cellular Phone _____ E-mail Address _____

Occupation _____ Employer _____ No. of years _____

If child, parents' work phone _____

Business Address _____
Employer City Phone

Marital Status _____ Patient's Social Security No. _____

Name of Spouse _____ Spouse's occupation _____

Spouse's employer _____
Name of Employer Address Phone

Insurance Information (If you have any type of insurance, please complete)

VISION

Name of insurance company _____

Name of vision plan _____

Employee _____ Employee social security no. _____

MEDICAL

Name of insurance company _____

ID/ Group number _____

Medical History

Name of physician _____ City _____ Phone _____

Do you have a current medical problem? YES ☐ NO ☐ What _____

Have you ever had any of the following:

- ☐ Psychological Issues
- ☐ Lung trouble (TB, asthma, emphysema)
- ☐ Hepatitis, liver disease, jaundice
- ☐ Arthritis, sore joints
- ☐ Diabetes
- ☐ Use of tobacco products
- ☐ Blood trouble, anemia, leukemia
- ☐ STD (syphilis, gonorrhea, herpes)
- ☐ Aids or HIV
- ☐ Alcohol, drug or substance abuse
- ☐ Thyroid problems
- ☐ Cancer
- ☐ Heart attack or heart disease
- ☐ Rheumatic fever
- ☐ High blood pressure
- ☐ Fainting spells, convulsions, epilepsy
- ☐ Headaches when lying down
- ☐ Other health problems (Describe)

Medical History (continued)

Are you now:

- ☐ Pregnant
- ☐ On a prescribed diet
- ☐ Using thyroid meds
- ☐ Using hormones (including birth control)
- ☐ Using anticoagulants
- ☐ Using seizure meds
- ☐ Using other medicines (please specify) _____

Are you now taking or using medicines for:

- ☐ Diabetes (pills or shots)
- ☐ Anxiety/Depression
- ☐ Sleeping
- ☐ Heart or blood pressure
- ☐ ADD/ADHD
- ☐ Blood (iron pills)
- ☐ Stomach trouble (ulcer, other)
- ☐ Headaches
- ☐ Arthritis or rheumatism
- ☐ Allergy

Have you ever been sick from, shown an allergy to, or told not to take: _____

- ☐ Antibiotics
- ☐ Codeine
- ☐ Aspirin
- ☐ Contact lens solutions
- ☐ Novocaine (or other dental anesthetic)
- ☐ Other drugs or medicines (please specify) _____

Have you ever:

- had a tumor or cancer? YES ☐ NO ☐ Where? _____
- had a major operation? YES ☐ NO ☐ What kind? _____
- been in a serious accident? YES ☐ NO ☐ Describe: _____

	YES	NO
Following injuries, have you ever had bleeding problems?	☐	☐
Do injuries and cuts take longer to heal now than previously?	☐	☐
Have you had dental trouble recently?	☐	☐
Do you urinate more than 6 times daily?	☐	☐
Have you recently lost weight unintentionally?	☐	☐

Is there a history in your family of:

Father (F), Mother (M), Brother (B), Sister (S), Grandparents (GP), Aunt (A), Uncle (U)

_____ Diabetes _____ Heart problem _____ Eye disease _____ Thyroid

_____ Color blindness _____ Blindness _____ High blood pressure

_____ Glaucoma _____ Cataracts _____ Cancer _____ Other

In case of emergency notify: _____ Phone _____

OCULAR HEALTH:

Do you wear prescription glasses? _____ contact lenses _____ (hard/gas permeable/soft) (daily/extended wear)

Date of last eye exam _____ Date of last prescription lens change: _____

Having any problems with your contact lenses? YES ☐ NO ☐ Describe: _____

Do you feel your vision is inadequate at: distance _____ intermediate _____ near _____

Reason for today's visit: _____

Please check any eyes symptoms you are experiencing:

- ☐ Itching
- ☐ Light sensitive
- ☐ Headaches
- ☐ Pain in and around eyes
- ☐ Gritty/sandy feeling/dry eyes
- ☐ Redness
- ☐ Double vision
- ☐ Tearing
- ☐ Styes
- ☐ Burning
- ☐ Spots/light flashes
- ☐ Discharge

Have you ever had eye:

- ☐ Surgery
- ☐ Vision training
- ☐ Color blindness
- ☐ Glaucoma
- ☐ Lazy eye
- ☐ Crossed eye/muscle problems
- ☐ Injuries
- ☐ Cataract
- ☐ Other
- ☐ Disease
- ☐ Blindness

I have completed this preclinical examination questionnaire to the best of my knowledge:

Signature _____ Date _____