

Busby Eye Care
Patient History Questionnaire

Date _____
Last Name _____ First Name _____ MI _____ Date of Birth _____
Address _____ City _____ Zip _____ email _____
Telephone(H) _____ (W) _____ (C) _____ Social Security # _____
List Family Members _____ Spouse _____
Occupation _____ Employer _____
Emergency Contact/Telephone # _____
Date of Last Exam _____ Whom may we thank for referring you? _____

Medical Information

Do you have problems with any of these systems?

Eyes Y/N	Gastrointestinal Y/N	Nerves Y/N	Ears/Nose/Throat Y/N
Genitourinary Y/N	Endocrine Y/N	Cardiovascular Y/N	Musculoskeletal Y/N
Blood/Lymph Y/N	Respiratory Y/N	Integumentary (Skin) Y/N	Allergic Y/N

Please explain _____

Please answer all that apply

Diabetes Y/N Type _____ Date of Diagnosis _____
Allergies Y/N Allergic to what? _____ What happens? _____
Medication Allergy Y/N To what? _____
Headaches Y/N _____
Other Health Problems _____
Current Medications _____
Have you had any operations Y/N Kind? _____ When? _____
Do you use cigarettes/tobacco? _____ Alcohol? _____ Other Substance? _____
Name of Family Doctor _____ Date of last visit _____ Date of last tetanus shot _____

Family History

High Blood Pressure Y/N Relation _____	Macular Degeneration Y/N Relation _____
Diabetes Y/N Relation _____	Retinal Detachment Y/N Relation _____
Glaucoma Y/N Relation _____	Cataracts Y/N Relation _____
Other eye conditions Y/N What kind? _____	Relation _____

Personal Eye Information

Have you had any eye surgeries? Y/N Type _____ Date _____
Have you had any eye injuries? Y/N Type _____ Date _____
Do you have glaucoma? Y/N Cataracts? Y/N Dry Eye? Y/N Blurred Vision Y/N
Other eye problems Y/N Explain _____
Do you currently wear glasses? Y/N When? _____
Have you ever worn contact lenses? Y/N
If so, what style? Disposable Extended Wear Gas Permeable Bifocal Unsure
Are you interested in wearing contact lenses? Y/N
Do you work at a computer or video display terminal? Y/N How many hours per day? _____
What hobbies or sports do you participate in? _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____

Name of Employer _____

Insurance Company _____ Group # _____ Employer # _____

Do you have additional insurance? Y/N If YES, please complete the following:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____

Name of Employer _____

Insurance Company _____ Group # _____ Employer # _____

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Phone Number _____

Address if different from patient _____

Signature of patient (or parent if a minor)

Date

Please review the Busby Eye Care Financial Policy