Busby Eye Care

Patient History Questionnaire

Date_____

Last Name_____ First Name_____ MI____ Date of Birth_____

Address_____ City _____ State _____ Zip _____

Telephone (H) _____ (W) _____ (C) _____

Email_____ 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 Conditions:_____

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_____

Have you been diagnosed with: Glaucoma? Y/N Cataracts? Y/N Dry Eye? Y/N Blurred Vision Y/N

Other eye conditions: Y/N Explain_____

Insurance Information/Responsible Party

VISION INSURANCE

☐ No Insurance

Insurance Company_____ Policy Holder's Employer_____

Name of insured_____ Relationship to patient_____

Birthdate _____ Social Security #_____

Address if different than patient _____ Phone # _____

MEDICAL INSURANCE

☐ No Insurance

Insurance Company_____ Policy Holder's Employer_____

Name of insured_____ Relationship to patient_____

Birthdate _____ Social Security #_____

Address if different than patient_____Phone#_____

ADDITIONAL INSURANCE PLANS

Insurance Company_____ Policy Holder's Employer_____

Name of insured_____ Relationship to patient_____

Birthdate _____ Social Security #_____

Address if different than patient _____ Phone # _____

_____ _____

Signature of patient (or parent if a minor) Date

Please review the Busby Eye Care Financial Policy and complete the Patient Lifestyle Questionnaire