



PATIENT HISTORY QUESTIONNAIRE

(completion required at each patient appointment)

Please answer all questions.

Last name _____ First name _____ MI _____
 Address _____
 Telephone (W) _____ (H) _____
 SSN _____ - _____ - _____ Date of birth _____ Male (M) or Female (F) _____
 Occupation _____
 Employer _____
 Emergency contact/Telephone number _____
 Date of last eye exam _____ Dilated? _____ Today's date _____

Medical Information

What is your general health? _____

Do you have problems with any of these systems? (please circle all that apply)

Eyes	Y/N	Eyes	Y/N
Gastrointestinal	Y/N	Nervous	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N
		Mental	Y/N
		Endocrine (glands)	Y/N
		Blood/lymph	Y/N
		Allergic/immunologic	Y/N

Please explain _____
 Diabetes? Y/N Type _____ Date of diagnosis _____
 Allergies? Y/N Allergic to what? _____ What happens? _____
 Medication allergy? Y/N What happens? _____ Headaches? Y/N
 Other health problems _____
 Current medication(s) _____
 Have you had any operations? Y/N Kind? _____ When? _____
 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 _____

Personal Eye Information

Other eye condition(s)? Y/N What kind? _____ Date _____
 Have you had any eye operations? Y/N Type _____ Date _____
 Have you had an eye injury? Y/N Kind _____ Date _____
 Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred vision? Y/N
 Other eye problems? Y/N What kind? _____
 Do you wear glasses? Y/N Contact lenses? Y/N Type _____
 Additional information _____
 Whom may we thank for referring you? _____

Doctor's initials _____

VSP ADDITIONAL PATIENT INFORMATION

Today's Date _____

Patient's Name _____

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?
Name of friend or relative _____

If not referred, how did you choose our office?

- Another Dr.
- Insurance List
- Saw Sign/Building
- Newspaper/Radio/TV
- Yellow Pages: Which directory? _____
- Web Page: Which Web Site? _____
- Other _____



Patient Medical History

Do you use cigarettes/tobacco, alcohol, or other substances? Yes No

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

Lifestyle Questions

Do you..... (check box if your answer is yes)

- ..work at a computer? If yes, please complete computer questionnaire.
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in a "test drive" of the latest contact lens designs
- ..spend time outdoors? How much? __Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..have interest in a non-surgical approach to vision correction?
- ..have more than 1 pair of current Rx eyewear?
- ..have children?
- ..have family members in need of eye care?

Have you ever experienced, been diagnosed or treated for any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses | |
| <input type="checkbox"/> Other eye disorders _____ | |

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Eye History

Have you ever tried contact lenses? Yes No

Do you currently wear contact lenses? Yes No

What kind? _____

Solutions used _____

Are you satisfied with the vision and comfort of your contact lenses? Yes No

Would you prefer clear contact lenses or colored contact lenses? Clear Colored

If you wear bifocals, do the lines or head tilting bother you? Yes No

Insurance Information

Please note that insurance MAY NOT cover the Contact Lens Follow-up Evaluation.

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date ___/___/_____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth date ___/___/_____

Do you participate in a flex spending account?

___ Yes ___ No

How will you settle your account today?

___ Cash ___ Check ___ Credit Card

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:

No Yes (Please check boxes)

Relationship
(Mother's or Father's side)

- Blindness _____
- Cataracts _____
- Corneal Problems _____
- Diabetes _____
- Glaucoma _____
- Heart Disease _____
- Lazy Eye _____
- Macular Degeneration _____
- Retinal Problems _____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Family Eyecare of Winterset PC.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, your credit card will be utilized and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)

Please enter your credit card number and expiration date.

CC#: _____

Expiration Date: _____

Signature _____



Dr. Joseph Johll and the Staff of Family Eyecare of Winterset, P.C. are dedicated to ensuring high quality eye health care while providing the most accessible experienced, comprehensive patient care possible. Our goal is to exceed our patients' expectations with state of the art vision care and efficient, caring and friendly service. Our practice is committed to staying in the forefront of eye care technology with the latest instrumentation and continuing education for the Doctor and Staff. Our mission is to provide the highest quality of life for you, your family and our community in the years to come.



Computer User Questionnaire

Many people experience a variety of symptoms after working at their computer for some period of time. Surprisingly, many don't relate those symptoms directly to using the computer. Instead, they mistakenly attribute headaches and tired eyes to overall stress at work, rather than to visual fatigue that can be alleviated simply with the proper eyewear prescription.

If you experience any of these symptoms, please indicate the level of discomfort below:

<i>Symptom</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>
Headaches during or after working at the computer	_____	_____	_____
Overall bodily fatigue or tiredness	_____	_____	_____
Burning eyes	_____	_____	_____
Distance vision is blurry when looking up from the computer	_____	_____	_____
Dry, tired or sore eyes	_____	_____	_____
Squinting helps when looking at the computer	_____	_____	_____
Neck, shoulders, or back pain	_____	_____	_____
Double vision	_____	_____	_____
Letters on the screen run together	_____	_____	_____
Driving/night vision is worse after computer use	_____	_____	_____
"Halos" appear around objects on the screen	_____	_____	_____
Need to interrupt work frequently to rest eyes	_____	_____	_____

If you experience any of these symptoms, we offer a new type of eyewear lens that can eliminate the symptoms and dramatically improve your comfort level when working on a computer. These eyewear lenses result from new technology developed specifically for computer users. Our office has been trained and certified to pass this exciting technology on to you.

Please give this questionnaire to the Doctor for an explanation of how these eyewear lenses can help you.

Patient name: _____ Date: _____