

PATIENT HISTORY QUESTIONNAIRE & ACKNOWLEDGEMENT OF OFFICE POLICIES

Thank you for choosing City Center Optometry for your eye care needs! Please help us by completing this form accurately.

I certify that my responses on this form are accurate to the best of my knowledge. I certify that I understand cancellations on eyeglasses are not permitted as all eyeglasses are custom crafted for each patient with their unique prescription. I certify that I understand that there are no refunds or exchanges and that all sales are final. I also agree to refrain from cell phone use in the office.

PATIENT: _____/_____/_____/_____/_____
First Name Middle Name Last Name Suffix(i.e. Jr.) Preferred Name/ Nickname

Chief Complaint (Symptoms / Problems): _____

Do you have Blurred Vision?()Yes ()No Visual Discomfort?()Yes ()No Red Eyes?()Yes ()No Dry Eyes?()Yes ()No Itchy Eyes?()Yes ()No Watery Eyes?()Yes ()No Burning Eyes?()Yes ()No Dizziness?()Yes ()No Nausea?()Yes ()No Seasickness?()Yes ()No Previous Eye Injury?()Yes ()No Headaches?()Yes ()No Other Eye Problems?()Yes ()No _____

Date of Last Eye Exam: _____ Name of Attending Eye Doctor: _____

How would you describe your overall eye health?()Excellent ()Good ()Fair ()Poor

Date of Last Dental Exam: _____ Name of Attending Dentist: _____

How would you describe your overall dental health?()Excellent ()Good ()Fair ()Poor

Date of Last Medical Exam: _____ Name of Attending Doctor/Nurse Practitioner: _____

How would you describe your overall general health?()Excellent ()Good ()Fair ()Poor

Any prior surgeries?()Yes ()No If Yes, please list surgeries and date(s) _____

What is your occupation? _____ What hobbies or activities do you enjoy? _____

Have you ever worn prescribed glasses?()Yes ()No Any over-the-counter glasses?()Yes ()No

If Yes, for what purpose are/were they worn? ()General ()Distance ()Reading ()Computer ()Sports ()Safety ()Sun

Are you interested in trying contact lenses?()Yes ()No Are you interested in Refractive Surgery?()Yes ()No

Do you wear protective sunwear?()Yes ()No

Do you use a computer?()Yes ()No

If Yes, how many hours per day? _____ How far away is your monitor, in inches? _____ What is your monitor type?()Flat Panel ()CRT

Current Contact Lens Wearers: When were you first fit with Contact Lenses?: _____

What type do you wear? ()Soft ()Rigid Gas Permeable ()Toric ()Multifocal ()I don't know

Do you ever sleep while wearing contacts?()Yes ()No What solutions do you use to maintain your contacts? _____

How many hours per day do you wear your contacts? _____ How many days per week do you wear your contacts? _____

How often do you normally put on a new fresh pair of contacts? _____

If wearing contacts today, how many times have they been worn? _____ How many hours have they been in your eyes today? _____

Personal & Family Health History (i.e. children, parents, siblings, aunts, uncles, and grandparents-- whether living or deceased)

Have you or any immediate blood relative experienced any of the following?

High Blood Pressure () Yes () No Blindness () Yes () No Macular Degeneration () Yes () No

Diabetes () Yes () No Eye Surgery () Yes () No Retinal Detachment () Yes () No

Thyroid Disease () Yes () No Turned Eye () Yes () No Glaucoma () Yes () No

Cancer () Yes () No Cataract () Yes () No Amblyopia (Lazy Eye) () Yes () No

Other: _____

Do you take any prescribed medications?()Yes ()No Any over-the-counter medications?()Yes ()No

If Yes, please list all medications here: _____

Do you have any known allergies to medications?()Yes ()No

If Yes, please list: _____

Do you have any known allergies to environmental factors (i.e. latex, metals, foods, animals, pollen, dust, mold)?()Yes ()No

If Yes, please list: _____

Review of Systems: Do you have any problem with any of these systems?

Gastrointestinal ()Yes ()No Nerves ()Yes ()No Psychological ()Yes ()No Eyes ()Yes ()No

Ears/Nose/Throat ()Yes ()No Urinary ()Yes ()No Endocrine(glands) ()Yes ()No Teeth ()Yes ()No

Cardiovascular ()Yes ()No Bones ()Yes ()No Blood/Lymph ()Yes ()No Skin ()Yes ()No

Respiratory ()Yes ()No Allergic/Immunologic ()Yes ()No

If Yes, please explain: _____

Female Patients: Are you pregnant?()Yes ()No If Yes, how many months? _____

If you have taken or are taking oral contraceptives or hormonal supplements, please indicate length of Rx history: _____

Patients under 18 years of age: Has there been any history of developmental problems?()Yes ()No

If Yes, please list the developmental problem(s): _____

Signature of Responsible Party Full Name of Responsible Party DATE SIGNED (MM-DD-CCYY) -2008