

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.

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

Chief Complaint (Symptoms / Problems/ Main Reason for Visit): _____

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 or Treatment? ()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? _____

Do you use a computer? ()Yes ()No If Yes, how many hours per day? _____ How far away is your monitor, in inches? _____

Have you ever worn **prescribed** glasses? ()Yes ()No

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

Have you ever worn any **over-the-counter reading glasses**? ()Yes ()No Do you wear **protective sunwear**? ()Yes ()No

Are you interested in Contact Lenses? ()Yes ()No Are you interested in Refractive Surgery? ()Yes ()No

Contact Lens Wearers: List the year you were first fit with Contact Lenses _____ When were they last worn? _____

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

What solutions do you use to maintain your Contact Lenses? _____

Do you ever **sleep** while wearing Contact Lenses? ()Yes ()No If Yes, How many nights in a row? _____

After how many days of Contact Lens wear do you put on a **new, fresh pair of Contact Lenses**? _____

My **wearing schedule** is _____ H/D, _____ D/W, _____ D/M, and/or _____ days and nights of continuous wear.

If **wearing Contact Lenses today**, how long have they been continuously in your eyes? _____ (for the Right Eye) _____ (for the Left Eye).

Including today, the right Contact Lens has been worn for _____ days, and the left Contact Lens has been worn for _____ days.

Personal & Family Health History: Have **you** or **any immediate blood relative** (i.e. children, parents, siblings, aunts, uncles, and grandparents--
whether living or deceased) 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
High Cholesterol () Yes () No	Turned Eye () Yes () No	Glaucoma () Yes () No
Thyroid Disease () Yes () No	Amblyopia (Lazy Eye) () Yes () No	
Cancer () Yes () No	Cataract () Yes () No	Other: _____

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

If Yes, please list all **prescribed and over-the-counter 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): _____

I certify that my responses on this form are accurate to the best of my knowledge. **I certify that I understand that a cancellation fee of \$48 will be charged if I fail to appear, or if I cancel or reschedule within 24 hours of any scheduled appointment.** 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.

Signature of Responsible Party Full Name of Responsible Party DATE SIGNED (MM-DD-CCYY) -2018