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.

_____/ _____/ _____ - _____ -2019
Signature of Responsible Party Full Name of Responsible Party DATE SIGNED (MM-DD-CCYY)