Original A3

Patient History Questionnaire

Today's Date _____

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name _____ First Name _____ MI _____
Address _____ City _____ State_____ Zip _____
Email_____ Home Phone_____
Date of Birth_____ Occupation_____ Employer _____
Emergency Contact Name _____ Phone Number_____
Date of Last Eye Exam _____ Dilated? Yes/No Policy holder name_____
Primary Vision Coverage _____
Last 4 of insured SS#_____

Medical Information

How is your general health? _____
Do you take medications for any of these systems? **(Please circle yes or no.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain _____
Diabetes Yes/No_____ Type _____ Date of diagnosis _____
Allergies to medication Yes/No Which? _____ Reactions? _____
Other health problems _____
Current medication(s)_____
Have you had any operations? Yes/No Kind? _____ When? _____
Name of family doctor and/or primary care physician _____
Date of last visit _____ Date your blood pressure was last checked _____

Family History

High blood pressure	Yes/No	Relation _____	Macular degeneration	Yes/No	Relation _____
Diabetes	Yes/No	Relation _____	Retinal detachment	Yes/No	Relation _____
Glaucoma	Yes/No	Relation _____	Cataracts	Yes/No	Relation _____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind?_____
Have you had any eye operations? Yes/No Type _____ Date _____
Have you had an eye injury? Yes/No Kind_____ Date _____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contact lenses?	Yes/No	Type _____	

Additional information _____

How did hear about us: YELP___ FACEBOOK_____ FRIEND/FAMILY____ INSURANCE____ OTHER_____

I hereby authorize Apple Contact Lens Center to release information to and receive payment from my insurance company with my signature on file. I am responsible for any non-payment billed services or materials not paid by my insurance. I have read and understand the notice of Privacy Practices.

Signed_____ Date_____

*I agree to pay all attorneys fees, court costs, filing fees & collection costs. Up to 50% of amt. owing may be assessed by any collection agency retained to pursue the matter. I agree to pay interest @ the rate of 1.5% per mo.