



PATIENT HISTORY QUESTIONNAIRE

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

Last Name _____ First Name _____ MI _____
 Address _____ City _____ State _____ Zip _____
 Work Phone _____ Home Phone _____
 Date of birth _____ Occupation _____ Employer _____
 Emergency Contact Name _____ Phone Number _____
 Date of Last Eye Exam _____ Dilated? Yes / No Referred By: _____
 Primary Vision Coverage _____ Secondary Coverage _____

Reviewed by _____

Medical Information

What is your general health? _____

Do you have problems with 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 _____

Date of last visit _____ Date of last tetanus shot _____

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 _____

Reviewed by _____ o No Change Date _____

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, and collection costs. Up to 50% of amt. owing may be assessed by and collection agency retained to pursue the matter. I agree to pay interest @ the rate of 1.5% per mo.