Patient Questionnaire

❑ Mr. ❑ Mrs. ❑ Ms. Marital Status: ❑ S ❑ M ❑ D ❑ W Today's Date _____

Name: _____ Soc. Sec. # :_____
First Middle Last

If Minor Parents Soc. Sec. #_____

Address: _____ Date of Birth: _____

City, State, Zip: _____ Employer:_____

Phone: Home _____ Phone: Business _____

Name of ❑ Spouse or ❑ Parent (if minor): _____ Cell Phone: _____

❑ Spouse ❑ Parent Employment: _____ ❑ Spouse ❑ Parent Work Phone: _____

Insurance Information

Name of Company: _____ ID#:_____

Policy Holder's Name: _____ Group#: _____

Policy Holder's Date of Birth:_____ Medicaid#: _____

Policy Holder's Place of Employment:_____ Medicare#: _____

Fee Policy

Exam fee is due on date of examination. A deposit is required for glasses or contact lenses to be ordered. The balance is due when dispensed.

Method of Payment

❑ Cash ❑ Check ❑ Credit Card

I agree to pay for all services and materials provided by the office of Drs. Wolf & Hatfield.

Signature _____

Medical History

Name of Medical Doctor: _____ Last Medical Exam: _____

Do you have any allergies to medications? ❑ no ❑ yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

_____

_____

List all major injuries, surgeries and /or hospitalizations you have had: _____

_____

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury.

Are you interested in Lasik? ❑ no ❑ yes

Are you pregnant and/or nursing? ❑ no ❑ yes Last Eye Exam: _____

Do you wear glasses? ❑ no ❑ yes If yes, how old is your present pair of lenses?_____

Do you wear contact lenses? ❑ no ❑ yes If yes, how old is your present pair of lenses? _____

Family History

Are you interested in laser vision correction? ❑ no ❑ yes

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	DISEASE/CONDITION	NO	YES	?
Blindness	❑	❑	❑	Diabetes	❑	❑	❑
Cataract	❑	❑	❑	Heart Disease	❑	❑	❑
Crossed Eyes	❑	❑	❑	High Blood Pressure	❑	❑	❑
Glaucoma	❑	❑	❑	Macular Degeneration	❑	❑	❑
Retinal Detachment/Disease	❑	❑	❑	Other _____	❑	❑	❑

Please turn this form over and complete side two

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever	❑	❑	❑
Unusual Weight Loss/Gain	❑	❑	❑
INTEGUMENTARY (Skin)	❑	❑	❑
NEUROLOGICAL			
Frequent Headaches	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
EYES			
Blurred Vision	❑	❑	❑
Loss of Vision	❑	❑	❑
Distorted Vision/Halos	❑	❑	❑
Loss of Side Vision	❑	❑	❑
Double Vision	❑	❑	❑
Dryness	❑	❑	❑
Mucous Discharge	❑	❑	❑
Unusual Redness	❑	❑	❑
Sandy or Gritty Feeling	❑	❑	❑
Itching	❑	❑	❑
Burning	❑	❑	❑
Foreign Body Sensation	❑	❑	❑
Excess Tearing/Watering	❑	❑	❑
Glare/Light Sensitivity	❑	❑	❑
Eye Pain or Soreness	❑	❑	❑
Chronic Infection of Eye or Lid	❑	❑	❑
Styes or Chalazion	❑	❑	❑
Flashes/Floaters in Vision	❑	❑	❑
ENDOCRINE			
Thyroid/Other Glands	❑	❑	❑
ALLERGIC / IMMUNOLOGIC	❑	❑	❑

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❑	❑	❑
Sinus Congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Post-Nasal Drip	❑	❑	❑
Chronic Cough	❑	❑	❑
Dry Throat/Mouth	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
VASCULAR/CARDIOVASCULAR			
Diabetes	❑	❑	❑
Heart Conditions	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular Disease	❑	❑	❑
High Cholesterol	❑	❑	❑
GASTROINTESTINAL			
Diarrhea	❑	❑	❑
Constipation	❑	❑	❑
GENITOURINARY			
Genitals/Kidney/Bladder	❑	❑	❑
BONES/JOINTS/MUSCLES			
Osteo Arthritis	❑	❑	❑
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
LYMPHATIC/HEMATOLOGIC			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
PSYCHIATRIC	❑	❑	❑

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

_____

_____

_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❑ Yes, I would prefer to discuss my Social History information directly with my doctor. (check box)

Do you drive? ❑ no ❑ yes If yes, do you have visual difficulty when driving? ❑ no ❑ yes If yes, please describe:

_____

Do you use tobacco products? ❑ no ❑ yes If yes, type/amount/how long: _____

Do you drink alcohol? ❑ no ❑ yes If yes, type/amount/how long: _____

Do you use illegal drugs? ❑ no ❑ yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

_____ _____

Doctor's Signature Date