PATIENT HISTORY QUESTIONNAIRE

Last Name ______________________________First Name __________________________ DoB ______________
Address ____________________________________City ____________________State __________ Zip ________
Telephone (H) _______________(W) _________________ (C) ________________S.S.#______-______-______
Occupation ___________________________Employer __________________________ Single ☐ Married ☐
Emergency Contact/Phone # ___________________________________ Name of last eye Dr.___________________
Date of last eye exam ______________ Dilated? ____________ Referred by ____________________________
How did you hear about our office? ____
Is anyone in your family a patient of Dr. Andren's? Yes ☐ No ☐ Who? ___________________________
How many hours per day do you use a computer? __________ E-mail Address ______________________________

PERSONAL HEALTH HISTORY

	Yes	No		Yes	No
Asthma…………………..	☐	☐	Head or spinal injuries ……………	☐	☐
Kidney Disease …………	☐	☐	Seizures, fainting …………………	☐	☐
Diabetes…………………	☐	☐	Lupus …………………………….	☐	☐
# Of years……………..			HIV………………………………..	☐	☐
Insulin ………………….	☐	☐	Cancer …………………………….	☐	☐
Migraines ………………	☐	☐	Sickle cell anemia ………………..	☐	☐
Depression ……………..	☐	☐	High blood pressure ………………	☐	☐
Any nervous disorder …...	☐	☐	Stroke ……………………………..	☐	☐
Heart Disease …………...	☐	☐	Are you pregnant …………………	☐	☐
Ulcer ……………………	☐	☐	Do you use tobacco/alcohol ………	☐	☐
Arthritis …………………	☐	☐	or other substance ……………..	☐	☐
Hepatitis ………………...	☐	☐	Other health problems ……………	☐	☐

Please list all medications you are currently taking (including eye drops): _________________________________
____
List any medications that you are allergic to: ____
Surgical History: ____Family Physician: ____________________

PERSONAL EYE INFORMATION

	Yes	No		Yes	No		Yes	No
Cataracts ………	☐	☐	Corneal Disease …………	☐	☐	Crossed eyes…..	☐	☐
Glaucoma ……..	☐	☐	Retinal/macular Disease ..	☐	☐	Eye disorders ….	☐	☐

Do you wear: Eyeglasses? Yes ☐ No ☐ Contacts? Yes ☐ No ☐ (Soft/Hard)
Are you interested in wearing contact lenses? Yes ☐ No ☐ Did you have Lasik? Yes ☐ No ☐
Eye Surgery or Injuries: ______________________________ Right _______________ Left _________________

FAMILY HISTORY: Has anyone in your family (blood relative) had any of the following in the past?

	Yes	No		Yes	No		Yes	No
Glaucoma	☐	☐	Cataracts	☐	☐	Corneal Disease	☐	☐
Retinal/macular	☐	☐	Diabetes	☐	☐	Retinitis Pigmentosa	☐	☐
Diabetic Retinopothy	☐	☐	Stroke	☐	☐	Heart problems	☐	☐
Other health problems	☐	☐	other eye problems	☐	☐	Retinal detachment	☐	☐

CONSENT TO TREAT

By signing this form, I consent to treatment for myself and/or on the behalf of the Minor for which this information pertains. I give my permission for the doctor to examine, diagnose and initiate treatment as deemed appropriate. I further attest that I am the Parent/Legal Guardian of the Minor and have the authority to authorize care or treatment. **SIGNATURE:** ___________________________________ **DATE** ____________________
Name of Vision Insurance Carrier ____
Insured Name & SS # ____
While Dr. Andren is happy to submit to my insurance for me, I understand I am responsible for all charges should my claim be denied. SIGNATURE: ____

DOCTOR SIGNATURE____ DATE __________________