Union Eye Works
Patient History Questionnaire

Date: ___ / ___ / ____

Patient Information:

Full Name: ____

Address: ____

City: ______________________ State: _____ Zip: _______

Birth Date: ___/___/_____ SS #: ____/____/______

Home Phone:_______________________________________

Cell Phone: _______________________________________

Work Phone: ______________________________________

Email Address: _____________________________________

Communication Preference: ☐ Phone ☐ Email

Insurance Information:

Medical Insurance Carrier: __________________________

Vision Insurance Carrier: ____________________________

Name of Policy Holder: _____________________________

Policy Holder's Date of Birth: ________________________

Relationship to Patient: _____________________________

If this is your first visit to our office, how did you hear about us? ____

Medical History:

Name of Primary Care Physician: __________________________________ Approx. Date of Last Physical: ___/___/_____

Name of Previous Eye Doctor or Practice: ___________________________ Approx. Date of Last Eye Exam: ___/___/_____

What is the Reason for Your Visit Today? ____

Please List all Medications You are Currently Taking (including vitamins and over-the-counter medications):

____

____

Are you Allergic to any Medications? ☐ No ☐ Yes If yes, please list: _____________________________________

Ocular History:

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your current pair of lenses? _________________________

How often? ☐ All the time ☐ Occasionally ☐ Distance Tasks ☐ Near Tasks ☐ Computer

Do you wear contact lenses? ☐ No ☐ Yes If yes, what brand? ____

If yes, what type? ☐ Soft Spherical ☐ Soft Toric ☐ Soft Multifocal ☐ Other / Don't Know

Wear Schedule: ☐ Full-Time ☐ Part-Time ☐ Other: ____

Are you interested in learning about contact lenses today? ☐ Not sure ☐ Yes

Social History (☐ *Check here if you would prefer to discuss social history directly with the doctor*)

Do you have visual difficulties when driving? ☐ No ☐ Yes ☐ Only at Night ☐ Other: ______________

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 infected with: ☐ Gonorrhea ☐ Hepatitis ☐ Herpes ☐ HIV ☐ Syphilis

Are you currently pregnant and/or nursing? ☐ No ☐ Yes

Review of Systems (*Please place a check mark to indicate if you or a family member has had any of the following*)

Ocular	Self	Family	Medical	Self	Family
Amblyopia	☐	☐	Arthritis	☐	☐
Blindness	☐	☐	Asthma	☐	☐
Cataracts	☐	☐	Cancer	☐	☐
Dry Eyes	☐	☐	Diabetes	☐	☐
Eye Strain	☐	☐	Headaches	☐	☐
Eye Surgery / Trauma	☐	☐	Heart Disease	☐	☐
Eye Turn	☐	☐	High Blood Pressure	☐	☐
Floaters	☐	☐	High Cholesterol	☐	☐
Glaucoma	☐	☐	Migraines	☐	☐
Light Sensitivity	☐	☐	Thyroid (Please circle: hypo/hyper)	☐	☐
Macular Degeneration	☐	☐	Other: __________________________	☐	☐
Other: __________________________	☐	☐	Other: __________________________	☐	☐

Acknowledgement of Receipt of Notice of Privacy Practices and Insurance Release

By signing this statement, I am agreeing that I understand the HIPAA Notice of Privacy Practices. I am also acknowledging that Union Eye Works, LLC has made available a copy of the policy for my records.

Please be advised that as a participating provider with your insurance carrier, we will submit the appropriate claim for your examination. However, payment from the insurance company is dependent upon your eligibility as determined at the time of service.

Your signature below is your acknowledgement of the above statements as well as the acknowledgement that you are liable for any and all charges not covered by your insurance carrier.

____ ______________

Signature of Patient *Date*

____ ______________

Signature of Parent/Guardian if patient is under 18 years of age *Date*