Lake Optical, Inc.

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_____
Phone Numbers:
Home _____Cell _____Work_____

Date of Birth_____Occupation_____Employer_____

Date of Last Eye Exam_____Dilated ? Yes/No Referred By:_____

Medical Coverage_____Member ID Number_____Email Address_____

Medical Information/Family History/Personal Eye History: NO CHANGES FROM LAST VISIT _____(Initial)

MEDICAL INFORMATION (No need to complete remainder of form *if this visit is less than 12 mos. from last exam at Lake Optical **and** medical information has not changed.*)

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
Hypertension	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 Medications_____

Have you had any operations? Yes/No Kind_____When_____

Family Doctor_____Date of last visit_____Date of last tetanus shot_____

FAMILY HISTORY

Hypertension	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 HISTORY

Do you have any eye conditions or problems? Yes/No Kind_____

Have you had any eye operation? Yes/No Kind_____ 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/concerns_____

Please note : If we do not accept direct payment from your insurance plan, you will pay our office in full at the time of service and submit your receipt for reimbursement from your insurance company. If your insurance does not pay us as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits.

_____ _____
Patient's (Guardian's) Signature / Date Reviewed by / Date