

PATIENT HISTORY QUESTIONNAIRE

MATHER VISION GROUP

1401 Union Street
Lafayette, IN 47904

Date _____

Last Name _____	First Name _____	MI _____
Address _____	City _____	Zip _____
Telephone (H) _____	(W) _____	Date of Birth _____
Social Security Number _____	Insurance Name _____	Number _____
Occupation _____	Employer _____	
Emergency Telephone Number _____	Name of Contact _____	

Medical Information

What is your general health? _____

Do you have any problems with the following systems? (circle all that apply)

Gastrointestinal	Y / N	Nervous	Y / N	Mental Health	Y / N
Ears/Nose/Throat	Y / N	Genitourinary	Y / N	Endocrine (glands)	Y / N
Cardiovascular	Y / N	Musculoskeletal	Y / N	Blood/Lymph	Y / N
Respiratory	Y / N	Skin Disorders	Y / N	Immune System	Y / N

Please Explain _____

Have you had any operations? Y / N Explain if Yes _____

Do you currently use tobacco products? Y / N Alcohol Y / N

Please answer all that apply

Diabetes Y / N Type _____ Date of Diagnosis _____ Last glucose reading _____

Allergies Y / N Allergic to What? _____ What happens _____

Do you EVER suffer from red eyes, itchy eyes, watery eyes, or swollen eye lids? _____

Do you EVER use an over-the-counter eye drop (i.e. VISINE A, VISINE AC, OPCON A, etc.) to treat red eyes, itchy eyes, watery eyes, or swollen eye lids? _____

Do you take oral medication like CLARITIN, ALLEGRA, OR ZYRTEC for your allergies? _____

Medication Allergies? _____

High blood pressure Y / N Last reading? _____ Controlled Y / N

Frequent Headaches Y / N Location? _____

Current Medications _____

Family Doctor _____ Date of Last Visit _____

Family History

High blood pressure Y / N Relation _____ Macular degeneration Y / N Relation _____

Diabetes Y / N Relation _____ Retinal Detachment Y / N Relation _____

Glaucoma Y / N Relation _____ Cataracts Y / N Relation _____

Other eye conditions _____ Relation _____

Personal Eye Information

Have you had any eye operations? Y / N Type _____ Date(s) _____

Have you had an eye injury? Y / N Kind _____ Date(s) _____

Do you have glaucoma? Y / N Cataracts? Y / N Dry Eyes? Y / N Blurred Vision Y / N

Other eye problems? _____

Do you wear glasses? Y / N Contacts Y / N What Kind? _____

Do you have any special visual tasks or sports? _____

Additional information _____

Whom may we thank for referring you? _____ Doctors' Initials _____

It is our goal to provide you with the utmost care and professionalism. With this in mind, we ask you to be prompt with your payments for services rendered and/or materials received. Therefore, if insurance payment has not been received within 60 days, you are responsible for your account balance. In addition, a monthly service charge will be automatically added after 60 days, collection fees, and attorney fees — if necessary.

Parent/Patient Signature: _____ Date: _____