

NEW PATIENT HISTORY QUESTIONNAIRE

Last Name _____		First Name _____		MI _____
Single Married	Spouse or Parent Name _____			
Address _____		City _____	St _____	Zip _____
Telephone (H) _____		(W) _____	(C) _____	
Soc. Sec.# _____ - _____ - _____		Date of Birth _____		Sex: M F
Occupation _____		Employer _____		
Emergency contact: Name _____		Telephone _____		
Today's Date: _____				
Whom may we thank for referring you? _____				

MEDICAL INFORMATION

Check if you have any of the following:

Eyes <input type="checkbox"/> Blurred vision <input type="checkbox"/> Spots in vision <input type="checkbox"/> Redness <input type="checkbox"/> Double Vision	Gastrointestinal <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Other, please specify: _____	Neurological <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Parkinson's <input type="checkbox"/> Stroke <input type="checkbox"/> Other, please specify: _____	Psychiatric <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Bipolar <input type="checkbox"/> Depression <input type="checkbox"/> Other
Ears/Nose/Throat <input type="checkbox"/> Hearing impaired <input type="checkbox"/> Dry mouth <input type="checkbox"/> Hay Fever <input type="checkbox"/> Other, please specify: _____	Genitourinary <input type="checkbox"/> Herpes <input type="checkbox"/> Syphilis <input type="checkbox"/> Other, please specify: _____	Endocrine <input type="checkbox"/> Diabetes <input type="checkbox"/> Hyper or Hypo Thyroid <input type="checkbox"/> Marfan's Syndrome <input type="checkbox"/> Other, Please Specify: _____	
Cardiovascular <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Heart Attach <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Other, Please Specify: _____	Musculoskeletal <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Osteo Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other, please specify: _____	Blood/Lymph <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Clotting Disorder <input type="checkbox"/> Leukemia or Lymphoma <input type="checkbox"/> Other, Please Specify: _____	
Respiratory <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other, please specify: _____	Integumentary (skin) <input type="checkbox"/> Rosacea <input type="checkbox"/> Basel cell carcinoma <input type="checkbox"/> Other, please specify: _____	Immunologic <input type="checkbox"/> Allergies <input type="checkbox"/> Lupus <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Other, please specify: _____	Constitution <input type="checkbox"/> Good Health <input type="checkbox"/> Fair Health <input type="checkbox"/> Poor Health

Current Medications and dosages (including non prescription and nutritional supplements):

Drug Allergies _____

Headaches Y/N Pregnant Y/N

List any surgeries (past 5 years) _____

Name of Family Doctor _____ Date of last visit _____

Do you smoke or use tobacco? Y/N Alcohol? Y/N Other substance? Y/N

What activities, hobbies, or sports do you enjoy? _____

FAMILY HISTORY

	Y/N	Relation		Y/N	Relation
High Blood Pressure			MacularDegeneration		
Diabetes			Retinal Detachment		
Glaucoma			Cataracts		
Eye Turn			Lazy Eye		

PERSONAL EYE INFORMATION

Date of last eye exam _____ Were you dilated? _____

List any eye surgeries and dates _____

List any eye injuries and dates _____

Do you have: GLAUCOMA? Y/N CATARACTS? Y/N DRY EYES? Y/N
MACULAR DEGENERATION? Y/N EYE TURN? Y/N LAZY EYE? Y/N

Are you interested in the LASIK vision correction? Y/N

Do you wear glasses? Y/N Contact Lenses? Y/N Type _____ Solution _____

What is the primary reason for your visit today? _____

I have received a copy of Crockett Vision Center Notice of Privacy Practices with an effective date of 12/12/2002.

NOTE: Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your insurance representative. Although we will do our best to understand your benefits, we are sometimes unable to gather accurate information from your carrier. Please understand that **financial responsibility for your account is ultimately yours.** I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to Dr. Crockett.

Signed _____ Date: _____ E-MAIL: _____

If you have medical insurance please make sure to bring your insurance card with you to your appointment.