PATIENT QUESTIONNAIRE

Name _____ Date _____

Name of Parent (if patient is under 18) _____

Home Address _____ Birth Date _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Occupation _____ Employer _____

Referred by _____ Social Security Number _____

Please complete the following Questionnaire

Have you ever had Asthma?	Y	N	
Have you ever had Allergies?	Y	N	
Have you ever had Sinus Trouble?	Y	N	
Have you ever had Diabetes?	Y	N	
Have you ever had High blood pressure?	Y	N	
Have you ever had Thyroid problems?	Y	N	
Have you ever had Arthritis?	Y	N	
Have you ever had Heart Disease?	Y	N	
Do you have HIV?	Y	N	
Have you ever had Elevated Cholesterol?	Y	N	
Have you ever had Cancer?	Y	N	
Have you ever had a Stroke / T.I.A.?	Y	N	
Have you ever had Hepatitis?	Y	N	
Have you ever had T.B.?	Y	N	
Have you ever had Glaucoma?	Y	N	
Have you ever had Cataracts?	Y	N	
Have you ever had Blindness?	Y	N	
Have you ever had Lazy Eye?	Y	N	
Have you ever had Crossed Eye?	Y	N	
Have you ever had Macular Degeneration?	Y	N	
Have you ever had Ocular Trauma?	Y	N	
Have you ever had Surgery to your eyes?	Y	N	
Do you use tobacco?	Y	N	
Do you use recreational drugs?	Y	N	
How often do you drink alcohol?			

List all medication (prescription / nonprescription / supplements) that you currently use:

_____

_____

_____

Have you ever had an allergic reaction to medication: Y N _____

Is there any other information that you think we should know about? _____

_____

I acknowledge that the above information is true. I authorize the release of any information needed to facilitate treatment or to process insurance claims. I realize that I am fully responsible for any unpaid balance not covered by insurance.

Signature: _____