

MT. JULIET FAMILY VISION CENTER

DATE _____

ADULT HISTORY QUESTIONNAIRE	PATIENT INFORMATION	PLEASE PRINT
NAME: _____	NAME YOU PREFER TO BE CALLED _____	
ADDRESS _____	CITY _____	ST _____ ZIP _____
HOME PHONE _____	WORK _____	CELL _____
SOC. SEC # _____	BIRTHDATE _____	AGE _____ SEX: M F
PERSON RESPONSIBLE FOR THIS ACCOUNT _____		RELATIONSHIP TO PATIENT _____
IN CASE OF EMERGENCY, CONTACT _____		PHONE _____

INSURANCE INFORMATION	
MAJOR MEDICAL INSURANCE INFORMATION	
POLICYHOLDERS NAME _____	RELATIONSHIP TO PATIENT _____
BIRTHDATE _____	SOC. SEC # _____
EMPLOYER _____	PHONE _____
INSURANCE COMPANY _____	ID NUMBER _____
IS PATIENT COVERED BY ADDITIONAL INSURANCE? Y N INSURED'S NAME _____	
BIRTHDATE _____	SOC. SEC# _____ RELATIONSHIP TO PATIENT _____
INSURANCE COMPANY _____	ID NUMBER _____
VISION INSURANCE INFORMATION	
POLICYHOLDERS NAME _____	RELATIONSHIP TO PATIENT _____
BIRTHDATE _____	SOC. SEC # _____
PLEASE CIRCLE IF YOU HAVE ANY OF THE FOLLOWING: VSP VCP CIGNA VISION BLUECROSS/BLUESHIELD	

MEDICAL HISTORY
REASON FOR YOUR VISIT TODAY (indicate any specific vision problem or symptom) _____
ARE YOU INTERESTED IN CONTACT LENSES? Y N
DATE OF LAST EYE EXAMINATION _____ LAST EYE DOCTOR _____
RESULTS OF LAST EYE EXAMINATION _____
PRIMARY CARE PHYSICIAN _____ DATE OF LAST PHYSICAL _____
MEDICATIONS
LIST ALL CURRENT MEDICATIONS AND THE CONDITIONS THEY ARE FOR: _____

ANY ALLERGIES OR KNOWN MEDICINE ALLERGIES? _____
HAVE YOU EVER TAKEN ANY MEDICINES FOR A LONG PERIOD OF TIME? _____
SOCIAL HISTORY
TOBACCO: NONE SOCIAL MODERATE HEAVY ALCOHOL: NONE SOCIAL MODERATE HEAVY
SUBSTANCE ABUSE: Y N IF YES, LIST _____
PERSONAL & FAMILY HISTORY
DESCRIBE ALL SERIOUS ILLNESSES, INJURIES AND SURGERIES: _____
HAVE YOU OR ANY FAMILY MEMBER EVER HAD ANY OF THE FOLLOWING DISEASES/CONDITIONS?
X=SELF M=MOTHER F=FATHER B=BROTHER S=SISTER GF=GRANDFATHER GM=GRANDMOTHER
___DIABETES ___THYROID PROBLEMS ___MULTIPLE SCLEROSIS ___MACULAR DEGENERATION ___EMOTIONAL PROBLEMS
___HIGH BLOOD PRESSURE ___KIDNEY PROBLEMS ___EYE INJURY/SURGERY ___LAZY EYE/CROSSED EYES ___SINUS PROBLEMS
___HIGH CHOLESTEROL ___LIVER PROBLEMS ___GLAUCOMA ___VISION THERAPY ___MIGRAINES
___STROKE ___EPILEPSY ___CATARACTS ___ASTHMA ___HEAD INJURY/SURGERY
___HEART DISEASE ___CANCER ___RETINA DISEASE ___DIFFICULTY BREATHING ___NECK INJURY/SURGERY

FOR DOCTOR'S USE:
 Reviewed: ___/___/___ PD/MD Reviewed ___/___/___ PD/MD Reviewed ___/___/___ PD/MD Reviewed ___/___/___ PD/MD 08/09