

Patient Information Questionnaire

Date _____

Patient name _____ Nickname _____

First Last M.I.

Gender M F Birth date ____ / ____ / ____ Social Security # (SSN) ____ - ____ - ____

Address _____ City _____ State ____ Zip _____

Phone # Home _____ Work _____ Cell _____

Email address _____

Occupation _____ Employer _____

Vision Ins. _____ Medical Ins. _____ ID# _____

Insured's name _____

Gender M F Birth date ____ / ____ / ____ Social Security # (SSN) ____ - ____ - ____

Relation to patient _____ Insured's Medical Ins. Group/ID# _____

Emergency Contact

Name _____ Relation _____ Phone # (____) _____

If patient is a minor or youth covered by an adult's insurance, parent/guardian information:

Father's name _____ Address, if different _____

Father's phone number _____ Father's Vision Ins. _____

Father's birth date ____ / ____ / ____ Last four digits of father's SSN _____

Mother's name _____ Address, if different _____

Mother's phone number _____ Mother's Vision Ins. _____

Mother's birth date ____ / ____ / ____ Last four digits of mother's SSN _____

Name of School patient attends _____ Grade _____ Student ID # _____

If you have children, please list their names and ages here: _____

How did you learn about our practice? _____

If referred to this office, name of the person who referred you _____

Medical Information

Name of family doctor _____ Last physical _____

Doctor's address _____ Phone # _____

Name of last eye doctor _____

Address of last eye doctor, if not in Lodi _____

Date of last eye exam ____ / ____ / ____ Year of last spectacle or contact lens Rx _____

BURKE OPTOMETRY

Please check any of the following body systems with which you have a problem:

- Cancer/Fatigue syndrome, please explain below
- Sinus/Laryngitis/Hiatal hernia/Hearing Loss
- Migraine/Stroke/Epilepsy/MS/Cerebral palsy
- Depression/ Anxiety disorder/ Bipolar disorder
- Heart disease/Vascular disease/Hypertension
- Asthma/Bronchitis/COPD/Emphysema
- Celiac/Acid reflux/Crohn's/Ulcer/Colitis
- Prostate/Bladder/Kidney/Herpes/Chlamydia
- Arthritis/Fibromyalgia/Gout/Osteoporosis/Musc.Dystr
- Rosacea/Psoriasis/Eczema/Shingles/Cold sore
- Diabetes Type I/Diabetes Type II/Thyroid
- Anemia/Ulcer/ High Cholesterol
- Lupus/ Rheumatoid arthritis/Sjogren's syndr./Allergies

Please explain further: _____

Any medical operations? _____ Date _____

Previous eye surgery? If so, type _____ which eye? R L When _____

Previous eye injury? If so, what _____ which eye? R L When _____

For women, are you pregnant? Y N Or, are you nursing? Y N

List current medications (if you have a written list, we will photocopy it for you)

List over-the-counter or herbal supplements you take _____

Allergies to medicines & reaction you had (ex: hives, skin rash, difficulty breathing) _____

Other allergies _____

Please check any of the following eye/vision conditions you have:

- Glaucoma
- Strabismus
- Blurred Vision
- Double vision
- Cataract
- Keratoconus
- Tearing
- Itchy eyes
- Macular degeneration
- Dry eyes
- Eyestrain
- Lid twitch

Do you use eye drops? If so, name of drops _____

Do you drink alcohol? Y N If so, how much do you drink weekly? _____

Do you smoke or chew tobacco? Y N If so, how much? _____

If not, are you a former smoker? Y N

Hobbies, especially with particular visual requirements (ie: shooting, computer, quilting, piano): _____

How many total hours do you spend using the computer/tablet/smart phone each day? _____

Do you wear glasses? Y N Do you wear contact lenses? Y N

Are you interested in wearing contact lenses? Y N

Are you interested in laser vision correction? Y N

Family History

Please check any conditions that have been in your family and note the person in your family who has or had the problem for each (for example: brother has diabetes, mom had cataracts)

- Cancer _____
- High blood pressure _____
- Cataracts _____
- Glaucoma _____
- Other eye conditions _____
- Diabetes _____
- Thyroid _____
- Macular degeneration _____
- Retinal detachment _____

Signed _____ **Date** _____