BURKE OPTOMETRY

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:

School Name_____ Student Id no _____

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 _____

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
☐ Cataract
☐ Macular degeneration
☐ Strabismus
☐ Keratoconus
☐ Dry eyes
☐ Blurred Vision
☐ Tearing
☐ Eyestrain
☐ Double vision
☐ Itchy eyes
☐ 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 _____ ☐ Diabetes _____
☐ High blood pressure _____ ☐ Thyroid _____
☐ Cataracts_____ ☐ Macular degeneration_____
☐ Glaucoma _____ ☐ Retinal detachment _____
☐ Other eye conditions _____

Signed _____ **Date** _____