**Vision Exam- Patient History Questionnaire**

**Patient Name: ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Name/ Nick name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_**

**This questionnaire is designed to help your Doctors and Opticians find the best level of care to correct your visual needs. Please take a few moments to answer the following questions.**

**1. Are you experiencing any of the following problems with your eyes? (Check all that apply)**

|  |  |  |  |
| --- | --- | --- | --- |
| * **Blurriness** | * **Pain** | * **Itchiness** | * **Redness** |
| * **Light sensitivity** | * **Recent flashes** | * **Recent floaters /** | * **Other\_\_\_\_\_** |

**Increased floaters**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Personal**  **Yes** | | **Family**  **Yes Unknown** | |  |  | **Personal**  **Yes** | | **Family**  **Yes Unknown** | | | | | | |
|  | **Dry Eye** |  |  |  |  |  | **Heart disease** |  |  |  | |  |  | | | |
|  | **Hay Fever** |  |  |  | **Thyroid** |  |  | |  | | | |
|  | **Unexplained headaches** |  |  |  |  | **Weight loss** |  |  | |  | | | |
|  | **Cataracts** |  |  |  |  | **Asthma** |  |  | |  | | | |
|  | **Glaucoma** |  |  |  |  | **Kidney disease** |  |  | |  | | | |
|  | **Retinal Detachment** |  |  |  |  | **Arthritis** |  |  | |  | | | |
|  | **Lazy eye** |  |  |  |  | **Rashes** |  |  | |  | | | |
|  | **Macular Degeneration** |  |  |  |  | **Seizure** |  |  | |  | | | |
|  | **Eye injury or surgery** |  |  |  |  | **Anemia** |  |  | |  | | | |
|  | **Diabetes** |  |  |  |  | **Depression** |  |  | |  | | | |
|  | **High blood pressure** |  |  |  |  | **List all other concerns** |  |  | | | | |  |  |  |
|  | **High cholesterol** |  |  |  |  |  |  | | |  | | |  |  |  |

**Please list or attach medications and vitamins here:**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Init) \_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_**

\*Please note all credit card transactions are subject to a *3.75%* processing fee. To avoid the credit card processing fee, we accept cash, check or debit card/PIN.

\*\*Your appointment time is respectively reserved for you and you only. To avoid a $35 Late/ No Show Fee, please provide at least a 24hr notice if you need to cancel or reschedule your appointment. Thank you DFE Staff.

**Medical Plan Necessity Disclosure**

**At Designs for Eyes, we don’t just handle your vison care needs through your Vision Care plan. We also provide medical treatment through your Medical plan if necessary. We accept most plans including but not limited to Medicare and BCBS to name a couple. Our Doctors of Optometry test, diagnose, and treat a wide range of eye related health concerns that could lead to long term issues including blindness. Some of these items include Diabetic Retinopathy, Glaucoma, Macular Degeneration, high blood pressure and dry eyes. If a referral to an Ophthalmologist is still required, our doctors will coordinate your care.**

**In the event the Doctor has concerns of a medical nature or diagnose an issue that could impact the health of your eyesight, we will work with you to schedule a short separate appointment. The doctor will further explore and communicate a treatment plan, your Medical insurance will be billed, and we will collect your specialist co-pay at that time. Should your Medical insurance not cover charges in its entirety, we will promptly notify you in writing? You will also receive an EOB (explanation of benefits) from your Medical Insurance Provider.**

**We appreciate you and look forward to helping you for years to come! DFE staff.**

**Patient or Rep. Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Init) \_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_ Emergency contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reviewed by Dr.(Init) \_\_\_\_\_\_\_\_\_\_\_\_ Reviewed by DFE staff (Init) \_\_\_\_\_\_\_\_\_\_\_\_**

***YOUR* HEALTH IS *OUR* CONCERN. Therefore, IF your Medical plan requires additional co-pays, and you need financial assistance, PLEASE communicate this with our staff.**