Littlefield eye associates

Patient Questionnaire

Prefix: _____ First Name: _____ Middle Initial:____ Last Name: _____ Suffix:_____

Preferred Name (only if different than legal first name): _____ Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ Circle One: **M** or **F** Prefered Number (Circle One): **CELL HOME WORK**

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Address: _____ Apartment/Unit #: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ ☐ **I decline to have an email on file**

Email address on file is used for appointment reminders and access to the Littlefield Eye Associates Patient Portal where you may securely access invoices, receipts, and medical records

Occupation: _____ Preferred Language:_____

Race: _____ Ethnicity **(Circle One)**: Hispanic **OR** Non-Hispanic ☐ ***I choose not to specify**

Marital Status **(Circle One)**: Single Domestic Partner Married Divorced Widowed

Emergency Contact: _____ Relationship: _____ Phone: _____

HIPAA Release of Information (Health Insurance Portability and Accountability Act of 1996)

I authorize the release of information including diagnosis, records and financial information to the following individuals:

1.) _____ Relationship: _____

2.) _____ Relationship: _____

How did you hear about us? *Provider List* *Yellow Pages* *Internet Search* *Personal Referral - Name*: _____

Insurance Information (Fill in all applicable fields):

Vision Insurance: *VSP/METLIFE/CIGNA *EYEMED/SURENCY/HUMANA *SUPERIOR *NVA * UNDER MY MEDICAL INSURANCE

Policy Holder's Name: _____ Date of Birth:_____ Policy Holder's Last 4 of SS#: _____

Insured Relationship to Patient: **SELF** **SPOUSE** **PARENT**

Medical Insurance: _____ Plan Name: _____

Policy Holder's Name: _____ Date of Birth:_____ Policy Holder's Last 4 of SS#: _____

Insured Relationship to Patient: **SELF** **SPOUSE** **PARENT**

Social History

Do you smoke? **YES** or **NO** **Amount?** _____ **How many years?** _____

Do you drink alcohol? **YES** or **NO** **Amount?** _____

Do you use illegal drugs? **YES** or **NO** **Type?** _____

☐ **I choose not to specify any of the above social history questions**

Medical, Ocular, and Family History

Date of last eye exam: _____ Do you wear glasses? **YES** or **NO** If yes, how old are they? _____

Do you wear contact lenses? **YES** / **NO** / **I AM INTERESTED**

Current Brand: _____ **Daily / 2 Week / Monthly / Rigid Gas Permeable-**How old are they? _____

Do you drive? **YES** or **NO** Do you work on a computer? **YES** or **NO** Are you pregnant or nursing? **YES** or **NO**

List all current PRESCRIPTION medications: _____

_____

List all current OVER THE COUNTER medications: _____

List any known medication allergies: _____

List ALL past surgeries: _____

_____

Primary Care Physician (Please only list if you have established care with this Physician)

Medical Doctor: _____ Name/Location of Practice or Hospital: _____

Any other **related** treating Physician (For example Endocrinologist, Rheumatologist): _____

Preferred Pharmacy: _____ Location: _____

Patient Medical History

Eyes

Blurred Vision	YES____	NO____
Dryness	YES____	NO____
Sandy or Gritty Feeling	YES____	NO____
Redness	YES____	NO____
Itching	YES____	NO____
Poor Night Vision	YES____	NO____
Light Sensitivity	YES____	NO____
Eye Strain	YES____	NO____
Blindness	YES____	NO____
Retinal Disease	YES____	NO____
Macular Degeneration	YES____	NO____
Floaters or Spots	YES____	NO____
Discharge from the eyes	YES____	NO____
Styes or Chalazion	YES____	NO____
Double Vision	YES____	NO____
Eye Pain/Soreness	YES____	NO____
Excess Tearing/Watering	YES____	NO____
Lazy Eye	YES____	NO____
Glaucoma	YES____	NO____
Cataracts	YES____	NO____
Do you sleep with eyes open?	YES____	NO____

General

Anemia	YES____	NO____
Depression	YES____	NO____
Anxiety	YES____	NO____
Memory Loss	YES____	NO____
Weight Loss/Gain **(Circle One)**	YES____	NO____
Sleep Apnea	YES____	NO____

Ear, Nose, Throat

Allergies/Hay Fever	YES____	NO____
Sinus Congestion	YES____	NO____
Hearing Loss	YES____	NO____

Neurological

Chronic Headaches/Migraines	YES____	NO____
Seizures or Epilepsy	YES____	NO____
Stroke	YES____	NO____

Respiratory

Emphysema	YES____	NO____
Chronic Bronchitis	YES____	NO____
COPD	YES____	NO____
Asthma	YES____	NO____

Vascular/Cardiovascular

High Blood Pressure	YES____	NO____
Heart Condition	YES____	NO____
***If yes, please specify** _____		
High Cholesterol	YES____	NO____

Musculoskeletal/Autoimmune

Rheumatoid Arthritis	YES____	NO____
Arthritis	YES____	NO____
Lupus	YES____	NO____
Sjogren's Syndrome	YES____	NO____
Multiple Sclerosis	YES____	NO____

Other

Cancer	YES____	NO____
***If yes, please specify** _____		
STD	YES____	NO____
HIV/AIDS	YES____	NO____
Hepatitis-**TYPE?**_____	YES____	NO____
Kidney Disease	YES____	NO____
Skin Condition	YES____	NO____
***If yes, please specify**_____		

Endocrine

Diabetes-**TYPE?**_____	YES____	NO____
Thyroid Condition	YES____	NO____
Hormone Replacement	YES____	NO____

Please list any known eye disease or conditions:_____

Please list any additional conditions or elaborate on above if necessary: _____

_____

Family History-If yes, PLEASE INDICATE WHO

Blindness	YES____-_____ NO____	Cancer	YES____-_____ NO____
Cataracts	YES____-_____ NO____	Diabetes	YES____-_____ NO____
Glaucoma	YES____-_____ NO____	Heart Disease	YES____-_____ NO____
Macular Degeneration	YES____-_____ NO____	High Blood Pressure	YES____-_____ NO____
Retinal Disease	YES____-_____ NO____	Kidney Disease	YES____-_____ NO____
Retinal Detachment	YES____-_____ NO____	Lupus	YES____-_____ NO____

Other:_____