MEDICAL PATIENT QUESTIONNAIRE: *please fill out this form completely as it is useful for your exam and a requirement for your insurance company*

Name ______________________ **Date of Birth**______________ **M F**

Address ______________________ **Email** ______________________

Home # ______________ **Cell #** ______________ **Work #**______________ **Preferred Contact # H C W**

Primary Insurance ______________________ **Secondary Insurance** ______________________

Insurance Subscriber ______________________ **Date of Birth** ______________ **Relationship** ______________

Financially Responsible Name______________________ **DOB**__________ _____ **Relationship**______________

What is your prescription plan? PART D or COMMERCIAL Pharmacy info______________________

Emergency contact ______________________ **Relationship** ______________ **Telephone**______________

Who referred you to our office? ______________________ **PCP Name** ______________________

When was your last exam and where was it done? ______________ Family members seen at PEC? ______________

History of Eye Problems or Surgery: Cataract/Glaucoma / Macular Degeneration / Dry eye/ Trauma / LASIK /Retinal Detachment or

Other? ______________________ **Family History of Eye Disease**: ______________________

Medical History of: Diabetes / High Blood Pressure / Heart Disease / Rheumatoid Arthritis / Thyroid disease/ Other? ______________

______________________**Surgical History**: ______________________

Medications list: (If Partners patient, leave blank) ______________________

______________________**Medication Allergies:** ______________________

Do You Currently have any problems with the following?					
Eyes (i.e., red, pain, tear, itch, decreased vision)	Yes	No	Muscles/Joints (morning stiffness, pain, deformity)	Yes	No
General health (fever, weight loss/gain	Yes	No	Neurological (headache, weakness, seizure)	Yes	No
Ear, Nose, Throat (hearing loss, dry mouth)	Yes	No	Endocrine (diabetes, heat/cold intolerance)	Yes	No
Cardiovascular (heart disease, stroke, high BP)	Yes	No	External allergies and effect	Yes	No
Respiratory (cough, shortness of breath, wheeze)	Yes	No	Medication allergies and effect	Yes	No
GI (stomach issues, diarrhea, ulcers)	Yes	No	Psychiatric (depression, anxiety)	Yes	No
Kidney/Bladder (infections, wake at night to urinate)	Yes	No	Pregnant/breast feeding	Yes	No
If Yes to any of the above, please explain:					
Do you have a Pacemaker or Defibrillator?					

Do you have **specific visual needs**? ______________________ What is your **occupation?** ______________

Social History: Have you ever Smoked? Y N If Yes, how much? __________ How many years? ________ **Do you smoke now? Y N**

Do you drink Alcohol? Y N how often? ____________ **Recreational Drugs or Medical Marijuana? Y N** how often? __________

Is Visit Accident Related? ________**If yes: Industrial Accident or Auto Injury Date of Injury**____________ **(fill out additional form)**

I authorize the release of any information necessary to process claims rendered by Putnoi Eye Care. I authorize the payments of any benefits to Putnoi Eye Care. I acknowledge that if any insurance does not cover services rendered that I will be responsible for payment.

Signed______________________ **Date**______________________