Perspective Eye Care
Medical Questionnaire

Patient Information: **(PLEASE PRINT)**

Last Name__________________________ First Name__________________________ M.I.__________

Date of Birth________________________ Sex: M F

Address____ Apt. #________

City ____ State__________ Zip__________

Home Phone__________________________________ Cell Phone____________________________

Marital Status: ________________________________ Employment Status: ____________________________

(Married, Single, Divorced, Widowed) (FT, PT, Retired, Not Employed, Student)

Insurance Information:

Vision Insurance______________________ Medical Insurance________________________

Name of Policy Holder___________________________ DOB of Policy Holder______________________

Relationship to Insured: Self Spouse Child Last 4 of Insured's SS#:____________

Medical History:

Last eye exam: ________________________ Last Physical Exam: ___________________________

(if elsewhere)

Please check all that apply below:

Your General Health	Family Health History
☐ Seasonal Allergies	☐ Diabetes
☐ Diabetes: Type?____________ How long?________	☐ High Blood Pressure
☐ Cancer	☐ Cancer
☐ Headaches	☐ Blindness
☐ Heart Disease	☐ Cataracts
☐ High Blood Pressure	☐ Glaucoma
☐ Thyroid Disease	☐ Macular Degeneration
☐ Eye Disease/Injury_____________________________	☐ Other______________________
(ie. glaucoma, cataracts, macular degeneration) Which eye? When?	
☐ Eye Surgery_________________________________	
(ie. Lasik, cataract surgery, retinal surgery) Which eye? When?	
☐ Other____	

List any other health conditions you are currently being treated for:_____________________________________

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List all medications, including eye medications you are currently taking:________________________________

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List any medication allergies:____

We require payment in full/or insurance co-pays at the time services are rendered. I acknowledge that Perspective Eye Care will file my insurance, but I am responsible for any unpaid portion or rejected claimes for the services rendered.

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Patient Signature or parent (if minor) Date