

DUBLIN FAMILY VISION CENTER
PATIENT QUESTIONNAIRE

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PERSONAL INFORMATION

CIRCLE ONE

HAVE YOU BEEN ILL RECENTLY? YES NO
HAVE YOU BEEN HOSPITALIZED RECENTLY? YES NO
HAVE YOU EVER HAD A SERIOUS EYE INJURY? YES NO
ARE YOU CURRENTLY TAKING ANY MEDICATIONS (INCLUDING BIRTH CONTROL)? YES NO
Please list any prescription or over the counter items: _____

ARE YOU AWARE OF ANY HEART PROBLEMS? YES NO
HIGH BLOOD PRESSURE? YES NO
HIGH CHOLESTEROL? YES NO
ARE YOU DIABETIC? YES NO
DO YOU NOW, OR HAVE YOU EVER WORN CONTACT LENSES? YES NO
ARE YOU INTERESTED IN CONTACT LENSES? YES NO
DO YOU HAVE ANY ALLERGIES? YES NO
If yes, please list: _____
ARE YOU BOTHERED BY FREQUENT HEADACHES? YES NO

FAMILY INFORMATION

IS THERE A HISTORY OF HIGH BLOOD PRESSURE IN YOUR FAMILY? YES NO
Please list the family members this pertains to (ex: father, sister, grandmother, etc.): _____
IS THERE A HISTORY OF DIABETES? If so which family member? _____ YES NO
IS THERE A HISTORY OF GLAUCOMA? If so, which family members? _____ YES NO
IS THERE A HISTORY OF CATARACTS? If so, which family members? _____ YES NO
IS THERE A HISTORY OF MACULAR DEGENERATION? _____ YES NO

PATIENT INFORMATION

NAME OF FAMILY PHYSICIAN: _____
WHEN WAS YOUR LAST PHYSICAL EXAM? _____
WHEN WAS YOUR LAST EYE EXAM? _____

PATIENT NAME: _____ BUSINESS PHONE: _____
ADDRESS: _____ EMPLOYMENT: _____
CITY: _____ STATE: _____ OCCUPATION: _____
ZIP CODE: _____
HOME PHONE: _____ PARENT'S NAMES (if under 18): _____
BIRTHDATE: _____ AGE: _____ NAME OF SPOUSE: _____
SOCIAL SECURITY #: _____

RESPONSIBLE PARTY/INSURANCE COMPANY: _____

VERIFICATION OF INSURANCE IS NOT A GUARANTEE OF PAYMENT

ANY BALANCE IS THE SOLE RESPONSIBILITY OF THE PATIENT

SIGNATURE: _____ DATE: _____

THANK YOU!