

Patient History Questionnaire
Welcome to Underwood Optical

Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Telephone (Home) _____ (Work) _____ SSN _____ - _____ - _____
Date of Birth _____ Age _____ **E-Mail address** _____
Occupation _____ Employer _____
Spouse's or Parent's Name _____ Emergency Contact # _____

The reason for your visit today is _____
How did you learn of our services: (Circle one) Yellow pages Dr. Referral Sign Location
Friend (whom may we thank _____)

Please indicate your method of payment: Cash _____ Check _____ Credit Card _____ Insurance _____
The following insurance's below we participate with and will bill for you. Any other insurance will be your responsibility to bill directly after payment in full to Underwood Optical:

Medicare/Medicaid _____ Utah Medicaid _____ VSP _____ RMHMO _____ Empire Electric _____

I consent to treatment as necessary or desirable to the care of the patient named above, including but not limited to medications or other studies that may be used by the attending optometrist, or qualified designate. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. In the event legal action should become necessary to collect an unpaid debt for optical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court deems proper. I hereby authorize payment of medical insurance to Dr. Underwood, and authorize release of any medical information acquired in the course of my examination of treatment.

SIGNATURE _____ Who is responsible for this bill _____
Date of Last Eye Exam _____ Dilated? _____ Today's Date _____

MEDICAL INFORMATION – TO BE FILLED OUT BY PATIENT

What is your general health? _____

Do you have problems with any of these systems? (please circle all that apply)

| | | | | | |
|------------------|-------|----------------------|-------|----------------------|-------|
| Gastrointestinal | Y / N | Nervous | Y / N | Eyes | Y / N |
| Ears/Nose/Throat | Y / N | Genitourinary | Y / N | Mental | Y / N |
| Cardiovascular | Y / N | Musculoskeletal | Y / N | Endocrine (glands) | Y / N |
| Respiratory | Y / N | Integumentary (skin) | Y / N | Blood/lymph | Y / N |
| | | | | Allergic/immunologic | Y / N |

Please explain _____

Please answer all that apply:

Diabetes Y / N Type _____ Date of Diagnosis _____

Allergies Y / N Allergic to what? _____ What happens? _____

Medication allergy Y / N What happens? _____ Headaches Y / N

Other health problems _____

Current medication (s) _____

Have you had any operations? Y / N Kind? _____ When? _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substance(s)? _____

Name of family doctor _____ Date of last visit? _____

Date of last tetanus shot _____

FAMILY HISTORY

High blood pressure Y / N Relation _____ Macular degeneration Y / N Relation _____

Diabetes Y / N Relation _____ Retinal detachment Y / N Relation _____

Glaucoma Y / N Relation _____ Cataracts Y / N Relation _____

Other eye conditions(s) Y / N What kind? _____ Relation _____

PERSONAL EYE INFORMATION

Have you had any eye operations? Y / N Type _____ Date _____

Have you had an eye injury? Y / N Kind _____ Date _____

Do you have glaucoma? Y / N Cataracts? Y / N Dry eyes? Y / N Blurred vision? Y / N

Other eye problems? Y / N What kind? _____

Do you wear glasses? Y / N Contact lenses? Y / N Soft _____ Toric _____ Hard _____

Additional information _____ Doctors Initials _____