VISIOPRO EYECARE
7237 N. Canton Ctr Rd.
Canton, MI 48187
PH 734-416-5005
FX 734-416-9720

BELLEVILLE VISION CTR
10788 Belleville Rd.
Belleville, MI 48111
PH 734-697-6671
FX 734-697-9332

PATIENT HISTORY QUESTIONNAIRE

This questionnaire is to be reviewed at each appointment. Please answer all questions. All information is strictly confidential and will help the doctor better understand you and your conditions.

General Information

Last Name _____ First Name_____ MI
Address_____ City _____ State _____ Zip
Home Phone _____ Cell Phone _____ Work Phone
Date of Birth____/____/_____ Sex: □M □F Occupation_____ Employer
Employment Status:□ Full time □Part Time □ Student □Retired Marital Status:□S □M □D □W
Soc Sec# _____-_____-_____ **Email Address**
Emergency Contact: Name _____ Phone

Date of Last Exam _____ Dilated? Y N
Primary Care Physician _____ Date of last visit _____ Pharmacy#

Patient History:

Ocular History

Do you or any family members have any of these problems? **Please circle yes or no or F for family.**

		Family member			Family member
Any eye conditions/problems?	Y N F	_____	Dry Eyes?	Y N F	
Eye injuries?	Y N F	_____	Macular Degeneration?	Y N F	
Glaucoma?	Y N F	_____	Retinal Detachment?	Y N F	
Cataracts?	Y N F	_____	Blurred Vision?	Y N F	
Do you wear glasses?	Y N F	_____	Do you wear contacts?	Y N F	
			Brand		

Additional Info:

Medical History:

Do you smoke? How much per day? _____ Are you pregnant or nursing?
Do you have problems with any of these systems? **Please circle yes or no.**

Gastrointestinal	Y N	Nervous	Y N	Endocrine	Y N
Ear/Nose/Throat	Y N	Urinary	Y N	Blood/Lymph	Y N
Cardiovascular	Y N	Muscles/Bones	Y N	Allergic/Immunologic	Y N
Respiratory	Y N	Skin	Y N	Headaches	Y N
High Blood Pressure	Y N	Eyes(Medically)	Y N	Mental	Y N

Please explain any conditions you circled yes to above:

Diabetes Y N Type: □I □II Date of diagnosis_____ Last A1C
Allergies to medications? Y N If yes what medication? _____Reaction
Other health problems?
Current Medications_____ Check if none □
Have you had any operations? Y N Kind & Date?

Medical History continued....

Family History

Does your family have any history of the following? **Please circle yes or no.**

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

Social History

Please fill out the following information to the best of your ability. All information is strictly confidential.

Tobacco Use

□ None
□ Former smoker
□ Light smoker, less than 1 pack per day
□ Average, 1-2 packs per day
□ Heavy, more than 2 packs per day

Stopped smoking

□ Within last year
□ 1-2 years ago
□ 3-4 years ago
□ 4-5 years ago
□ 5+ years ago
□10+ years ago

Narcotics Use

□ None
□ Recreational use
□ Chemical dependence

Alcohol Use

□ None
□ Social only
□ 1-2 drinks daily
□ Above average
□ Alcohol dependence

Insurance Information

Medical Insurance

Insurance Carrier:_____ ID Number:
Subscriber Name:_____ Relationship to Patient:
Subscriber Date of Birth:_____ Employer:

Vision Insurance

Insurance Carrier:_____ ID Number:
Subscriber Name:_____ Relationship to Patient:
Subscriber Date of Birth:_____ Employer:

I hereby authorize any necessary medical treatment by the optometrist in the practice of Belleville Vision Center or VisionPro Eyecare and agree to be responsible for my bill and any collection fees made necessary to collect payment of services rendered. I authorize this office to release any information necessary to expedite insurance claims. I further authorize the office of Belleville Vision Center or VisionPro Eyecare to release or obtain any required medical information from my attending physicians or any medical facility.

Print Patient Name_____ Signature
(Parent or responsible member if minor)

Responsible member if minor_____ Date _____