Cullison Eye Care

Patient Information & Medical History Questionnaire

Name: Dr/Rev/Mr/Mrs/Ms_____ Date:_____
Address:_____ City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Work Phone: _____
Date of Birth:_____ Age:_____ Last Eye Exam:_____ Last Medical Exam:_____
Occupation: _____
Whom may we thank for referring you to us?_____

Insurance Information:

Name of Insured: _____ Relationship to Patient:_____
Date of Birth: _____ **Social Security # of Insured**: _____
Insurance Co: _____ Group #:_____ Member ID: _____

Medical History:

Please specify if you or any of your relatives have any of these conditions?

	Self	Relative		Self	Relative
Diabetes	☐	☐	HIV	☐	☐
High Blood Pressure	☐	☐	Hepatitis	☐	☐
Heart Disease	☐	☐	Gonorrhea	☐	☐
Thyroid Disease	☐	☐	Syphilis	☐	☐
Kidney Disease	☐	☐	Lupus	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐
Arthritis	☐	☐	Cataracts	☐	☐
Stroke	☐	☐	Macular Disease	☐	☐
Sarcoidosis	☐	☐	Retinal Detachment	☐	☐
Blood Disorders	☐	☐	Eye Surgery	☐	☐
Asthma	☐	☐	Eye Injury	☐	☐
Depression/Psychiatric	☐	☐	Other _____		

	Yes	No		Yes	No
Pregnant or nursing?	☐	☐	Ocular floaters?	☐	☐
Frequent headaches?	☐	☐	Do you wear glasses?	☐	☐
Do you have seizures?	☐	☐	Do you wear contacts?	☐	☐
Do you smoke?	☐	☐	Interested in contacts?	☐	☐
Itchy or dry eyes?	☐	☐	Interested in Lasik?	☐	☐

Please list all current medications: _____

_____

_____

Please list any drug allergies: _____

_____

Office Use Only:

Notes: _____

_____

Reviewed by:

Initials _____ Date _____	Initials _____ Date _____	Initials _____ Date _____
Initials _____ Date _____	Initials _____ Date _____	Initials _____ Date _____