Affinity Eye Care
Medical History Questionnaire

Date _____

Patient's name _____ ❑Mr. ❑Mrs. ❑Ms. ❑Dr.

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Texting ok? ❑ Email ok? ❑

Who referred you to our office? (Name) _____

❑Insurance listing ❑Friend/Relative ❑Physician/Eye Doctor

Patient's date of birth _____ Last 4 numbers of Social Security Number _____

Occupation Employer _____

Special visual demands (work or hobbies) _____

Name of spouse _____

Please list any members of your household who come to our office _____

_____

Please check the box if you have ever had any of the following: ❑Glaucoma ❑Cataracts ❑Macular Degeneration ❑Lazy Eye ❑Eye Infections ❑Allergies ❑High Blood Pressure ❑High Cholesterol ❑Diabetes

List any other medical problems _____

List any medications you take regularly _____

Are you allergic to any medications? ❑Yes ❑No List _____

Do you smoke? ❑Yes ❑No

Have you ever had an injury or surgery to your eyes? ❑Yes ❑No Describe _____

Have any immediate relatives had glaucoma, macular degeneration, or other loss of sight?

❑Yes ❑No Describe _____

Do you currently wear glasses? ❑Yes ❑No How old are the glasses?

When do you wear them? _____

Do you currently wear contact lenses? ❑Yes ❑No ❑Soft ❑Hard or Gas permeable

If yes, how old are the contacts? _____ If no, have you ever worn contacts? ❑Yes ❑No

Do you have vision insurance? ❑Yes ❑No Name _____

Do you have health insurance? ❑Yes ❑No Name and ID# _____

Please note: Insurance may cover only part of your charges. If we do not accept direct payment from your insurance plan, you will need to pay our office and submit your receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We will be happy to assist you with your claims; please give any forms to the receptionist.

Patient signature _____ Date _____