PATIENT QUESTIONNAIRE

OFFICE USE ONLY: ACCOUNT# _____

Please circle one: Dr. Mr. Mrs. Ms. Miss

First Name _____ MI_____ Last Name _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____x _____ Cell (____) _____ - _____

Date of Birth _____/_____/_____ SS# _____-_____-_____

Email Address

Occupation_____ Employer_____ Flex Spending Acct.? Y / N

Vision Insurance _____ Insured Name & SS# _____

Medical Insurance_____ Insured Name & SS# _____

Ethnicity: (please mark one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Declined to Answer

Race: (please mark one) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race ☐ Declined to Answer

Preferred Language: (please mark one) ☐ English ☐ Spanish ☐ Other: _____ ☐ Declined to Answer

Are you diabetic or prediabetic? Yes No

Are you, or could you be pregnant? Yes No

Due Date_____

Do you use cigarettes / tobacco? Yes No

Alcohol? Yes No

Other substance(s)? _____

Are you color blind or do you have a hard time seeing colors? Yes No

Date of last Eye Exam _____

Were you dilated? Yes No

Name of family doctor _____

Date of last visit: _____

Would you like us to share your health information with a family member? Yes No

Name of authorized person _____

_____

How did you hear about our office? Google ◆ Yelp ◆ Facebook ◆ Yellow Pages ◆ Postcard ◆ Walk-in ◆ VSP Website

Internet (other): _____ Friend: _____

PLEASE PROVIDE A LIST OF ALL MEDICATIONS YOU ARE CURRENTLY TAKING

DRY EYE QUESTIONNAIRE

Have you experienced any of the following during the last week:

		All of the time	Most of the time	Half of the time	Some of the time	None of the time
1.	Eyes that are sensitive to light?	4	3	2	1	0
2.	Eyes that feel gritty?	4	3	2	1	0
3.	Painful or sore eyes?	4	3	2	1	0
4.	Blurred vision?	4	3	2	1	0
5.	Poor vision?	4	3	2	1	0
					[For office] Subtotal score for answers 1 to 5	(A)

Have problems with your eyes limited you in performing any of the following during the last week:

		All of the time	Most of the time	Half of the time	Some of the time	None of the time	
6..	Reading?	4	3	2	1	0	N/A
7.	Driving at night?	4	3	2	1	0	N/A
8.	Working with a computer or ATM machine?	4	3	2	1	0	N/A
9.	Watching TV?	4	3	2	1	0	N/A
					[For office] Subtotal score for answers 6 to 9	(B)	

Have your eyes felt uncomfortable in any of the following situations during the last week:

		All of the time	Most of the time	Half of the time	Some of the time	None of the time	
10.	Windy conditions?	4	3	2	1	0	N/A
11.	Places or areas with low humidity (very dry)?	4	3	2	1	0	N/A
12.	Areas that are air conditioned?	4	3	2	1	0	N/A
					[For office] Subtotal score for answers 10 to 12	(C)	

Add subtotals A, B. C to obtain D (D = sum of scores for all questions answered)	(D)

Total number of questions answered (Do not include questions answered N/A)	(E)