MIRA MESA EYECARE

Patient History Questionnaire

(must be updated at each visit)

Please select one: ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Miss. ◯ Dr. ◯ Rev.

Last name: _____ **First name:** _____ **Date of Birth:** _____
Address: _____ **City:**_____ **State:** CA **Zip:**_____
Phone: Home _____ **Cell** _____ **Work** _____
Email:_____ **How did you hear us?**_____
Primary language: _____ **Occupation/Employer:** _____
Please list any vision insurance: _____
Soc. Sec.#: _____ **Driv.Lic.#:** _____ **Exp:** _____

Responsible Party if different: _____ **Phone:** _____

METHOD OF PAYMENT: ◯ **CASH** ◯ **CREDITCARD** ◯ **INSURANCE** _____

HEALTH HISTORY (please check all that apply):
Do you or any of your immediate family members have the following conditions/diseases?

	YES	NO	Self/Family	
Lazy/crossed eyes?	☐	☐	☐	☐
Macular degeneration?	☐	☐	☐	☐
Cataract?	☐	☐	☐	☐
Glaucoma?	☐	☐	☐	☐
Diabetes?	☐	☐	☐	☐
High Blood Pressure/ High Cholesterol?	☐	☐	☐	☐

	YES	NO	please specify:
Do you have eye strains or headaches?	☐	☐	
Tired eyes/dry eyes?	☐	☐	
Do you smoke cigarettes/ tobacco?	☐	☐	
Drink Alcohol ?	☐	☐	
Other substances?	☐	☐	
Any vision surgery/ Head trauma/Eye injury?	☐	☐	

	YES	NO
Any other health problems or eye disease?	☐	☐
Do you currently take any medications?	☐	☐
Do you have any known allergies to any medication?	☐	☐
Trouble seeing at night without glasses?	☐	☐
Trouble seeing in the distance without glasses?	☐	☐
Trouble seeing close up without glasses?	☐	☐
Poor vision even with glasses on?	☐	☐

Please list any other current vision complaints: _____

Last eye exam: _____ **Doctor's name:** _____ **Phone:**_____

I authorize payment of medical or vision insurance to Mira Mesa Eye care.

_____ _____

PATIENT'S SIGNATURE (Parent/Guardian if minor) **DATE**

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