Performance Vision Care

Patient History Questionnaire

Mrs. Ms. Mr. Dr. _____ Date of Birth_____/_____/_____ Age _____

Address_____ City/State/Zip _____

Phone Number _____ Circle One: Home Cell Work

Email Address _____ Employer _____

Date of Last Physical _____ Family Doctor _____

Date of Last Eye Exam _____ Location _____

Type of exam you are here for (circle one): Contact Lenses Glasses Both

Preferred Method of Contact (circle one): Phone Email Text

How did you hear about us? _____

Medical Information

Please indicate if you or any family members have:

	Self	Family
Diabetes	_____	_____
High Blood Pressure	_____	_____
High Cholesterol	_____	_____
Suffered from a Stroke	_____	_____
Thyroid Disease	_____	_____
Glaucoma	_____	_____
Macular Degeneration	_____	_____

Please list current medications taken:

Do you suffer from allergies? Y N
If so, to what?

Personal Eye Information

Do you currently wear glasses?	Y	N
Do you currently wear contact lenses?	Y	N
Do you use a computer frequently?	Y	N
Do you get frequent headaches?	Y	N
Do you have problems with glare at night?	Y	N

Do you ever see double?	Y	N
Do you have a lazy eye?	Y	N
History of eye injuries or surgeries	Y	N
Do you ever see floaters?	Y	N
Do you ever see flashes of light?	Y	N

Insurance Information

Primary Insured's Name _____ Name of Vision Insurance_____

Primary Insured's Date of Birth _____ I.D. Number _____

Relationship to Patient_____ Medical Insurance _____

I request that payment of authorized benefits be made on behalf to Performance Vision Care for services rendered. In addition, I understand that I am responsible for any co-payments or deductibles required by my insurance company as any remaining balance not paid by my insurance.

Signature_____ Date _____

HIPPA Privacy Acknowledgement

I have been presented with the Notice of Privacy Policy of Performance Vision Care and have been offered a copy for my records.

Signature _____ Date _____