Date _____

Patient Health History Questionnaire

Name _____ Birth date_____ Current age_____

Home Phone_____ Cell Phone _____E-Mail _____

Home Address _____

Occupation _____ Employer _____ Work Phone _____

Soc Sec # _____ Date of Last Visual Exam _____ Marital Status: M W D S

Spouses Name _____ Spouses Employer _____ Insurance Provider _____

Medical Information

What is your general health? _____

Do you have problems with any of these systems? *Please circle all that apply.*

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Psychiatric	Y/N	Ears/Nose/Throat	Y/N	Genitourinary	Y/N
Endocrine (glands)	Y/N	Cardiovascular	Y/N	Musculoskeletal	Y/N
Blood/Lymph	Y/N	Respiratory	Y/N	Allergic/Immune	Y/N
Integumentary (skin)	Y/N	Neurological	Y/N	Constitutional	Y/N

Please Explain _____

Please answer all that apply:

Diabetes Y/N Type _____ Date of diagnosis _____

Allergies Y/N Allergic to what? _____ What happens? _____

Medication allergy? Y/N What Happens? _____ Headaches? Y/N _____

Current medications _____

_____

Any surgeries? Y/N Kind? _____ When? _____

Alcohol use? Y/N How much? _____ Smoke? Y/N How Much? _____

Former smoker? Y/N When did you quit? _____

Name of Family Doctor? _____ Date of last visit? _____

Personal Information

Height_____ Weight _____ Preferred language _____

Communication preference: Phone_____ (work,home,cell) E-mail_____

Family History

High blood pressure? Y/N Relation _____ Macular degeneration? Y/N Relation _____

Diabetes? Y/N Relation_____ Retinal detachment? Y/N Relation_____

Glaucoma? Y/N Relation _____ Cataracts? Y/N Relation _____

Any other Eye conditions? _____

You may share the following information related to my visits at Couvillion Eyecare with the following:

Name/Relationship _____ Name/Relationship _____
Billing _____ Medical _____ Billing _____ Medical_____

Patient Lifestyle Questionnaire

Do you wear Contact Lenses?_____ Are you interested in Contact Lenses?_____
How often and how long do you wear your glasses?_____
Do you have a backup pair of glasses?_____
What do you like most about your last eyewear?_____
What do you like least about your last eyewear?_____
Do you have problems with night driving or bright sunlight?_____
Do you have prescription sunglasses?_____
Do you work on a computer?_____ how many hours a day?_____
What kind of recreational activities are you involved in?_____
What kind of sports do you play?_____
Do you have Hobbies or special interests?_____
How important is your eyewear appearance to you? Very____ Fairly _____ Not at all_____
If I could show you a product that would benefit you both in comfort and improved vision would you be willing to invest more? Yes _____ No _____ Maybe _____
Special concerns you'd like the Doctor to address:_____

Acknowledgement of Receipt

I acknowledge that I have received a copy of Dr. Steven L Nottleson's Notice of Privacy Practices.

Patient Name _____ Date _____

Signature_____

_____