Michael V. Johnston, O.D., Optometrist

2110 12th Street, Harlan, IA 51537

Patient History Questionnaire

Full Name: _____, _____ Date of Birth: ____/____/____
Last First Middle

Address: _____ Home Phone: _____

Cell Phone: _____

_____ Work Phone: _____
City State Zip

Social Security #: _____

☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient's Employer: _____ Occupation: _____

Email Address: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Contact Peson's Phone #: _____

HEALTH INSURANCE:

Primary Insurance: _____ Secondary Insurance: _____

Name of Insured: _____ Name of Insured: _____

Member #: _____ Group#: _____ Member #: _____ Group#: _____

Person responsible for this account: _____ Phone #: _____

Address (if different): _____

Whom may we thank for referring you to our Practice? _____

Patient's Interests/Hobbies: _____

Do you spend a large amount of time on the Computer or Electronic Device? _____

Do you spend a large amount of time outdoors? _____

Ocular: Do you wear Glasses or Contact Lenses? _____ or Both? _____

Do you have a "back up" pair of glasses? _____ Are you: ☐ Right ☐ Left Handed

Medications: List all with dosage or provide a List: _____

_____

Surgeries: List all with dates/or provide a List: _____

_____

CONSTITUTIONAL SYSTEMS: Patient in Good Health? _____ If No, please explain: _____

_____

ALLERGIC: *Drug Allergies: _____ Other Allergies: _____

Your Primary Care Physician: _____ Location: _____

What Pharmacy do you use? _____ Location: _____

To the Patient - Check all that apply to you		Family History - (In Your Family)	
Cancer: Type _____	☐	Cancer: Type _____	Relative: _____
Diabetes: Type I or Type 2	☐	Diabetes: Type I or Type 2	Relative: _____
Eye Dieases: _____	☐	Eye Dieases: _____	Relative: _____
Eye Injury: _____	☐	Eye Surgery: _____	Relative: _____
Eye Surgery: _____	☐	Glaucoma: High or Low Risk	Relative: _____
Glaucoma: High or Low Risk	☐	Heart Disease: _____	Relative: _____
Heart Disease: _____	☐		

To the Patient - √ all that apply

CARDIOVASCULAR:
- High Blood Pressure? ☐
- Chest Pain/Angina? ☐
- High Cholesterol? ☐

EAR/NOSE/THROAT:
- Earaches? ☐
- Hearing Loss/Injury? ☐
- Nose Bleeds? ☐
- Sinus Problems? ☐
- Sore Throat? ☐

HEMATOLOGIC/LYMPHATIC:
- Anemia? ☐
- Bleeding/Bruising? ☐
- Slow to heal after cut? ☐

NEUROLOGICAL:
- Head Injury? ☐
- Headaches/Migranes? ☐
- Dizziness? ☐
- Stroke? ☐
- Seizures? ☐
- Numbness/Tingling? ☐
- Paralysis or Tremors? ☐

RESPIRATORY:
- Asthma? ☐
- Shortness of breath? ☐
- Persistent cough? ☐
- Emphysema? ☐
- Tuberculosis? ☐

MUSCULOSKELETAL:
- Arthritis? ☐
- Joint Pain/Stiffness? ☐
- Muscle Pain/Cramps? ☐
- Back Pain? ☐

PSYCHIATRIC:
- Anxiety? ☐
- Depression? ☐
- Memory Loss? ☐
- Insomnia? ☐
- Confusion? ☐

Check Yes or No

Have you ever used Tobacco Products? ☐ Yes ☐ No

Are you a current smoker? ☐ Yes ☐ No

Do you drink Alcoholic Beverages? ☐ Yes ☐ No

Comments: _____

_____

_____

To the Patient: To the best of your knowledge, the questions on this form have been accurately answered. You understand that providing incorrect information can be dangerous to your health. It is your responsibility to inform the Doctor's office of any changes in your medical status. You also authorize the health care staff to perform the necessary services you may need.

Patients' signature & date are required at each office visit, parent/guardian must sign for minor child.

Signature & Date: _____

Signature & Date: _____

Signature & Date: _____

Signature & Date: _____

Signature & Date: _____

Signature & Date: _____

Signature & Date: _____

Signature & Date: _____

Signature & Date: _____

For Doctor's Use Only:

Pt orientated to person/place/time: Yes No

HPI _____

Dr's Signature/Date _____

Pt orientated to person/place/time: Yes No

HPI _____

Dr's Signature/Date _____

_____

Pt orientated to person/place/time: Yes No

HPI _____

Dr's Signature/Date _____

_____

Pt orientated to person/place/time: Yes No

HPI _____

Dr's Signature/Date _____

_____

Pt orientated to person/place/time: Yes No

HPI _____

Dr's Signature/Date _____

_____

Pt orientated to person/place/time: Yes No

HPI _____

Dr's Signature/Date _____