

Update Questionnaire for Existing Patients

Name _____ date _____

Insurance details: please complete this section

Primary insurer _____

Policy number _____ **group** _____

Address _____

(if under your spouse add his/her full name & date of birth)

claims phone number _____

Secondary insurer _____

Policy number _____ **group** _____

address _____

claims phone number _____

Medical History: describe any changes in treatment, conditions and medications since your last exam

Primary Reason(s) for exam visit

We now provide in-office no touch wavefront lasik, ASA (lasik w/o the flap), ortho K (reshaping corneal lenses), refractive lens exchange and conductive keratoplasty. These procedures eliminate or reduce your need for eyeglasses. I would like more information. _____yes _____no

Payment options are available on professional, surgical and material fees over \$300.00. Options include no interest 3, 6, and 12 month terms as well as longer terms with interest. Paperwork is minimal and no payment is required at the time of visit. I would like more information. _____yes _____no.

REVIEW OF SYSTEMS: circle all that apply and provide a brief explanation.

Constitutional	no	yes	Ears, Nose, Mouth, Throat	no	yes
Fever, Weight Loss/Gain	n	y	Allergies/Hay Fever	n	y
Integumentary (skin)	n	y	Sinus Congestion	n	y
Neurological			Runny Nose	n	y
Headaches	n	y	Post-Nasal Drip	n	y
Migraines	n	y	Chronic Drip	n	y
Seizures	n	y	Dry Throat/Mouth	n	y
Eyes			Respiratory		
Loss of Vision	n	y	Asthma	n	y
Blurred Vision	n	y	Chronic Bronchitis	n	y
Distorted Vision/Halos	n	y	Emphysema	n	y
Loss of Side Vision	n	y			
Double Vision	n	y	Vascular/Cardiovascular		
Dryness	n	y	Diabetes	n	y
Mucous Discharge	n	y	Heart Pain	n	y
Redness	n	y	High Blood Pressure	n	y
Sandy or Gritty Feeling	n	y	Vascular Disease	n	y
Itching	n	y			
Burning	n	y	Gastrointestinal		
Foreign body Sensation	n	y	Diarrhea	n	y
Excess Tearing/Watering	n	y	Constipation	n	y
Glare/Light Sensitivity	n	y			
Eye Pain or soreness	n	y	Genitourinary		
Chronic infection	n	y	Genitals/Kidney/Bladder	n	y
Eyelid redness	n	y			
Tired eyes	n	y	Bones/Joints/Muscles		
Flashes/floaters	n	y	Rheumatoid Arthritis	n	y
			Muscle Pain	n	y
Endocrine			Joint Pain	n	y
Thyroid/Other Glands	n	y			
Lymphatic/hematologic			Allergic/Immunologic	n	y
Anemia	n	y	Psychiatric	n	y
Bleeding Problems	n	y			

Explanation
