Joseph J. Mueller O.D.

382 Main St.
Saugerties, NY 12477

(845)246-2872
Fax: (845)246-7628

PATIENT HISTORY QUESTIONNAIRE

MR_____MRS____MS____MISS____

MARRIED____SINGLE____WIDOWED___OTHER____

LAST NAME___________________________FIRST NAME__________________MI_____

ADDRESS____CITY_____________________

E-MAIL ADDRESS____

TELEPHONE (H)_________________________________(W)_________________________

SSN#____________________________________DATE OF BIRTH___________AGE____

OCCUPATION_________________________EMPLOYER___________________________

DATE OF LAST EXAM________________DILATED?_______TODAY'S DATE_________

REASON FOR VISIT: ROUTINE_ _____CONTACT LENSES__ ____EYE PROBLEM________

DO YOU WEAR GLASSES: Y/N IF YES, FOR DISTANCE____READING____
CONSTANT_____BIFOCAL______OTHER____

DO YOU WEAR CONTACT LENSES: Y/N IF YES, SOFT____GAS PERMEABLE____

MEDICAL INFORMATION

WHAT IS YOUR GENERAL HEALTH?____

DO YOU HAVE PROBLEMS WITH ANY OF THESE SYSTEMS: (PLEASE CIRCLE ALL THAT APPLY)

EYES Y/N NERVOUS Y/N MENTAL Y/N
GASTROINTESTINAL Y/N GENITOURINARY Y/N ENDOCRINE (GLANDS Y/N
CARDIOVASCULAR Y/N MUSCULOSKELETAL Y/N RESPIRATORY Y/N
INTEGUMENTARY (SKIN) Y/N BLOOD/LYMPH Y/N EARS/NOSE/THROAT Y/N
ALLERGIC/IMMUNOLOGIC Y/N
PLEASE EXPLAIN:____

DO YOU EVER HAVE ITCHY, RED, WATERY EYES? Y/N

DO YOU HAVE PROBLEMS WITH NIGHT DRIVING? Y/N

DIABETES Y/N TYPE_________DATE OF DIAGNOSIS____________________________

ARE YOU PREGNANT OR NURSING?______________________________

HAYFEVER ALLERGIES Y/N____

MEDICATION ALLERGIES Y/N____

HEADACHES Y/N OTHER HEALTH PROBLEMS___________________________________

(Over)

CURRENT MEDICATION(S)____

____

DO YOU USE CIGARETTES/TOBACCO?________________ALCOHOL?___________________

OTHER SUBSTANCE(S)?____

NAME OF FAMILY PHYSICIAN AND ADDRESS_____________________________________

____DATE OF LAST VISIT_________________

INSURANCE____

FAMILY HISTORY

HIGH BLOOD PRESSURE Y/N RELATION__________________________DIABETES Y/N RELATION __________
MACULAR DEGENERATION Y/N RELATION________ _GLAUCOMA Y/N RELATION_____
RETINAL DETACHMENT Y/N RELATION_________ ____ CATARACTS Y/N RELATION____
OTHER EYE CONDITION(S) Y/N WHAT KIND?_____________________________________
RELATIONS_______________________________________

PERSONAL EYE INFORMATION

HAVE YOU HAD ANY EYE OPERATIONS? Y/N TYPE_________________ DATE_________

HAVE YOU HAD AN EYE INJURY? Y/N KIND_______________________ DATE_________

DO YOU HAVE GLAUCOMA? Y/N CATARACTS? Y/N DRY EYES? Y/N
BLURRED VISION? Y/N

OTHER EYE PROBLEMS? Y/N

WHAT KIND____

ADDITIONAL INFORMATION____

WHOM MAY WE THANK FOR REFERRING YOU?___________________________________

METHOD OF PAYMENT (VISA/MC, DISCOVER, VISION PLAN, CASH OR CHECK)_______
PROFESSIONAL FEES ARE DUE AT THE TIME THE SERVICE IS RENDERED. IF GLASSES OR CONTACT LENSES ARE ORDERED, FULL PAYMENT IS REQUIRED WHEN ORDER IS PLACED. THIS INFORMATION IS CONFIDENTIAL AND WAS GIVEN BY (SIGNATURE).

____
Signature

THANK YOU,

JOSEPH J. MUELLER O.D. AND STAFF

REVIEWED BY____________________NO CHANGES DATE___________________________DR.'S INITIALS

REVIEWED BY____________________NO CHANGES DATE___________________________DR'S INITIALS

REVIEWED BY____________________NO CHANGES DATE___________________________DR'S INITIALS

REVIEWED BY________ NO CHANGES DATE DR'S INITIALS