PATIENT HISTORY QUESTIONNAIRE **DR. RICHARD ZOBEL, OD**

It is the Patient's responsibility to inform the office of any insurance before the examination.

LAST NAME_____FIRST NAME_____MI_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME_____WK_____CELL_____SS#_____DOB_____

EMAIL ADDRESS_____

OCCUPATION_____EMPLOYER_____

WHOM MAY WE THANK FOR YOUR REFFERAL_____

Name of VISION INSURANCE_____Name of MEDICAL_____

DATE OF LAST EYE EXAM_____PREVIOUS DR_____

PERSONAL HISTORY

NAME OF FAMILY DOCTOR_____

DO YOU HAVE PROBLEMS WITH ANY OF THESE SYSTEMS?

DIABETES…..	Y	N	Type I II
EARS/NOSE/THROAT	Y	N	
ALLERGIES……	Y	N	
CARDIOVASCULAR……	Y	N	
RESPIRATORY……	Y	N	
GENITOURINARY……...	Y	N	
MUSCULE/BONE…….	Y	N	
SKIN CONDITIONS…….	Y	N	
PSYCHOLOGICAL……...	Y	N	
ENDOCRINE (GLANDS)…..	Y	N	
BLOOD/LYMPH……	Y	N	
HIGH BLOOD PRESSURE…	Y	N	

Name of Family Doctor

_____

Ph #

_____

Address

_____

HAVE YOU HAD ANY OPERATIONS.....Y…..N TYPE_____

CURRENT MEDICATIONS _____

ALLERGIES TO MEDICATIONS…..Y…..N…..TYPE_____

PERSONAL EYE INFORMATION

HAVE YOU HAD ANY EYE OPERATIONS…Y…..N….. TYPE_____DATE_____

HAVE YOU HAD ANY EYE INJURIES……Y…..N…. TYPE_____DATE_____

DO YOU HAVE GLAUCOMA……Y….N….

CATARACTS……..…..Y…..N…. DO YOU WEAR GLASSES.…Y….N….

DRY EYES……....…..Y…..N…. CONTACT LENSES…..Y…..N…..

BLURRED VISION……...…Y….N…

FAMILY HISTORY

HIGH BLOOD PRESSURE……Y…..N…..RELATION_____Maternal/Paternal

MACULAR DEGENERATION… …..Y…..N…..RELATION_____Maternal/Paternal

DIABETES…… . Y…..N…..RELATION_____Maternal/Paternal

RETINAL DETATCHMENT……..Y…..N…..RELATION_____Maternal/Paternal

GLAUCOMA…… Y…..N…..RELATION_____Maternal/Paternal

CATARACTS……...Y…..N…..RELATION_____Maternal/Paternal

OTHER EYE CONDITIONS……...…Y.....N…..RELATION_____TYPE_____

I hereby grant permission for Dr. Zobel to exchange information with my insurance concerning my history/results of my examination diagnosis/treatment. I hereby assign all medical benefits to which I am entitled, I understand that I am financially responsible for all charges whether paid by said insurance. It will be the patients responsibility to provide our office with any required referrals. I authorize this office to release any information needed to determine these benefits for related service. Patients without insurance are responsible for all charges at time of visit.

Patients Signature_____**DATE**_____