Pleasant View Eye Care
218 Village Square Suite 100
Pleasant View, TN 37146

Please complete this questionnaire carefully. The following in-depth information will enable us to provide you with complete, quality eye care. If you have any questions we will be glad to help you.

Patient Information

Last Name:_____
Legal First Name:_____
Nickname:_____
Mr. Mrs. Miss Rev. Dr. Jr. Sr. I. II. III.
Street Address:_____
City:_____
State:_____ Zip:_____
Sex (M)or (F):_____
Social Security: _____
Birthdate:_____Age:_____
Employer:_____

Today's Date:_____

These are reserved for future visits
_____
_____

We enjoy acknowledging those who recommend our office. Please help us in doing so.
Referred by: Patient_____
If so whom?_____
Newspaper_____ Yellow Pages_____
Provider Book_____ Another Doctor_____

Phone Numbers and Contact Info

Home: ( )_____
Email address: _____
Cell: ( )_____
Daytime Number: ( )_____
In case of Emergency, contact: Name:_____ Relationship:_____
Phone:_____

Insurance

Insured **member** or **person responsible**.
Last Name:_____
First Name:_____
Street Name:_____
_____
City:_____ State:_____
Zip:_____
Social Security:_____
Birthdate:_____ Age:_____
Relationship to Patient:_____
Employer:_____
Work Phone:_____

Vision Insurance:_____
ID Number:_____
Plan/Group #:_____

Medical Insurance:_____
ID Number:_____
Plan/Group #:_____

Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract. To enable our office to file your insurance you must provide accurate information at each visit.

Eye / Health History

Primary Care Physician's Name:
_____
Date of last visit:_____
Eye Doctor's Name:_____
Date of last eye exam:_____
Do you wear glasses? Yes____ No_____
All the time:_____
Occasionally:_____ TV_____
Reading:_____ Driving:_____
Do you wear contacts? Yes_____ No____
Type:_____Hrs per day_____

Please circle YES or NO for *each* condition

Bloodshot Eyes	Y/N	Eye Injury	Y/N
Burning Eyes	Y/N	Floaters/Spots	Y/N
Cataracts	Y/N	Glaucoma	Y/N
Crossed Eyes	Y/N	Headaches	Y/N
Discharge	Y/N	Itching Eyes	Y/N
Double Vision	Y/N	Light Sensitive	Y/N
Dry Eye	Y/N	Red Eye	Y/N
		Watering Eye	Y/N

Health History

Please Circle Yes or No to indicate if you or a family member have had any of the following.

	Yourself	Family		Yourself	Family
AIDS/HIV	Y/N	Y/N	Hepatitis(Type ____)	Y/N	Y/N
Arthritis	Y/N	Y/N	High Blood Pressure	Y/N	Y/N
Artificial Heart Valve	Y/N	Y/N	Kidney Disease	Y/N	Y/N
Asthma	Y/N	Y/N	Lupus	Y/N	Y/N
Bleeding	Y/N	Y/N	Migraine Headaches	Y/N	Y/N
Blindness	Y/N	Y/N	Pacemaker	Y/N	Y/N
Cancer	Y/N	Y/N	Poor Color Vision	Y/N	Y/N
Cataracts	Y/N	Y/N	Retinal Disease	Y/N	Y/N
Chemical Dependency	Y/N	Y/N	Rheumatic Fever	Y/N	Y/N
Diabetes	Y/N	Y/N	Shingles	Y/N	Y/N
Drug Sensitivity	Y/N	Y/N	Skin Conditions	Y/N	Y/N
Emphysema	Y/N	Y/N	Stroke	Y/N	Y/N
Epilepsy	Y/N	Y/N	Thyroid Conditions	Y/N	Y/N
Eye Surgery	Y/N	Y/N	Tuberculosis	Y/N	Y/N
Glaucoma	Y/N	Y/N	Turned Eye	Y/N	Y/N
Hay Fever	Y/N	Y/N	Are you pregnant?_____		
Heart Condition	Y/N	Y/N	Tobacco Use_____ Alcohol Use_____		

Medications

List any medications you are currently taking, including eye drops:_____

_____

_____

Pharmacy Name:_____ Phone: ( )_____

Allergies

List your allergies to medications or other substances: _____

_____

_____

Signature:_____ **Date:**_____

These are reserved for future visits

Signature:_____ **Date:**_____

Signature:_____ **Date:**_____