Patient Information Questionnaire

Date: / /

FAMILY EYE CARE • DR. ALLEN BUTLER
200 DOCTORS DR • SUITE K • JACKSONVILLE, NC 28546 • (910) 353-0541

Name:_____DOB:_____Full SS#_____
FIRST MI LAST ☐Male ☐Female

Address:_____City:_____State:_____Zip:_____

Home Phone:(____)_____Work Phone:(____)_____Cell Phone:(____)_____Is Texting OK? ☐YES ☐NO

EmailAddress:_____Occupation:_____

Guardian (for minors):_____Spouse's Name:_____

Insurance Provider (Please present cards to receptionist):_____

Insurance Sponsor's Name: _____Full SS#: _____DOB: _____

Emergency Contact Name: _____Phone Number: (____)_____

Who may we thank for referring you? ☐Yellow Pages ☐Newspaper ☐Internet ☐Other_____

Medical Information

Name of family Doctor:_____Date of last visit:_____

Have you or a family member experienced or been treated for any of the following conditions? (Please check all that apply)

AIDs/HIV	☐Self / Family☐	Allergies	☐Self / Family☐	Arthritis	☐Self / Family☐
Asthma	☐Self / Family☐	Blood	☐Self / Family☐	Cancer	☐Self / Family☐
Ear/Nose/Throat	☐Self / Family☐	Gastrointestinal	☐Self / Family☐	Heart	☐Self / Family☐
Hypertension	☐Self / Family☐	Cholesterol	☐Self / Family☐	Kidney	☐Self / Family☐
Lupus	☐Self / Family☐	Neurological	☐Self / Family☐	Psychiatric	☐Self / Family☐
Seizures	☐Self / Family☐	Skin condition	☐Self / Family☐	Stroke	☐Self / Family☐
Respiratory	☐Self / Family☐	Headaches	☐Self / Family☐	Thyroid	☐Self / Family☐
Crossed Eye	☐Self / Family☐	Lasik or RK	☐Self / Family☐	Retinal Detach.	☐Self / Family☐
Glaucoma	☐Self / Family☐	Lazy Eye	☐Self / Family☐	Macular Deg.	☐Self / Family☐

Other or explanation of above: _____

Medications: _____

Diabetes: ☐Yes ☐No Type: ☐I ☐II Last blood glucose/A1C: _____/_____ Date of diagnosis: _____

Drug Allergies: ☐No ☐Yes:_____Type of Reaction:_____

Have you had any operations? ☐No ☐Yes:_____Date:_____

Personal Eye Information

Date of last eye exam: / /

Do you have any eye conditions or problems: ☐No ☐Yes: _____

Have you had any eye operations: ☐No ☐Yes:_____Date: / /

Have you had any eye injuries: ☐No ☐Yes: _____ Date: / /

Are you currently experiencing, or have experienced, any of the following? (Please check all that apply)

☐Blurry vision (☐Distance	☐Near)	☐Burning	☐Discharge	☐Double Vision	☐Excess Tearing/Watering
☐Sandy or gritty feeling	☐Eye Itch	☐Redness	☐Headaches	☐Light Sensitivity	☐Eye Pain or Soreness
☐Floaters or Spots	☐Dryness	☐Halos	☐Light Flashes	**☐Wearing glasses**	**☐Wearing contact lenses**

Doctor Use Only

Initial review by: _____

Reviewed by:_____Changes? ☐No ☐Yes:_____Date: / /

Reviewed by:_____Changes? ☐No ☐Yes:_____Date: / /

Reviewed by:_____Changes? ☐No ☐Yes:_____Date: / /

Reviewed by:_____Changes? ☐No ☐Yes:_____Date: / /