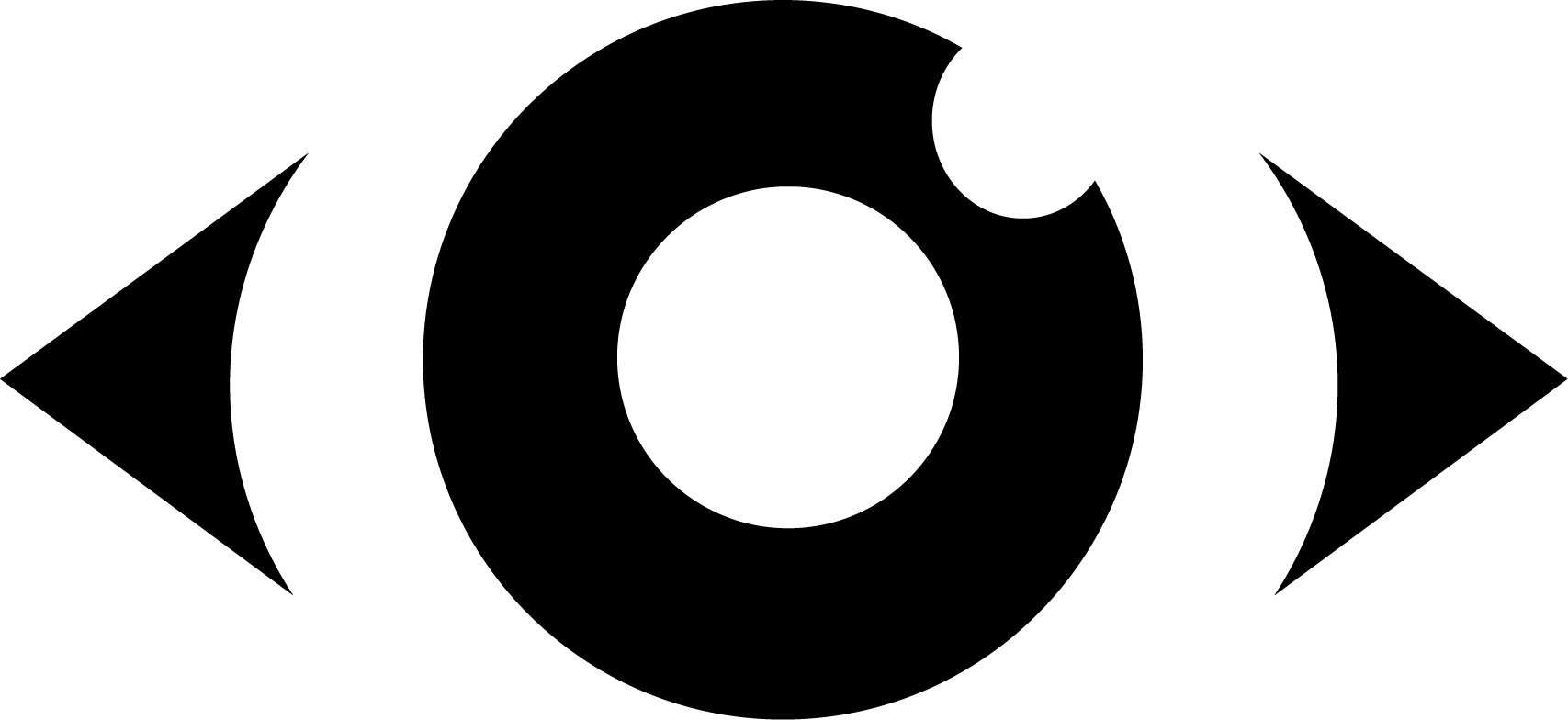
**Bellville-Canton Optometry**

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**VISIONPRO EYECARE**   **BELLEVILLE VISION CTR**

**1675 N. Canton Ctr Rd. 10798 Belleville Rd.**

**Canton, MI 48187 Belleville, MI 48111**

**PH 734-844-0400 PH 734-697-6671**

**FX 734-844-0403 FX 734-697-9332**

**PATIENT HISTORY QUESTIONNAIRE**

This questionnaire is to be reviewed at each appointment. Please answer all questions. All information is strictly confidential and will help the doctor better understand you and your conditions.

**General Information**

Last Name First Name MI

Address City State Zip

Home Phone Cell Phone Work Phone

Date of Birth / / Sex: □M □F Occupation Employer

Employment Status:□ Full time □Part Time □ Student □Retired Marital Status: □S □M □D □w

Soc Sec# - -

**Email Address**

(We have a private system to email reminders for appointments & notifications for orders)

Emergency Contact: Name Phone

Date of Last Exam Dilated? Y N

Primary Care Physician Date of last visit Pharmacy#

**Patient History:**

Ocular History

Do you **or** any family members have any of these problems?

**Y=Yes N=No F=Family** Family member Family member

Any eye conditions/problems? Y N F Dry Eyes? Y N F

Eye injuries? Y N F Macular Degeneration? Y N F

Glaucoma? Y N F Retinal Detachment? Y N F

Cataracts? Y N F Blurred Vision? Y N F

Do you wear glasses? Y N F Do you wear contacts? Y N F

Brand:

Additional Info:

**Medical History:**

Are you pregnant or nursing?

Do you have problems with any of these systems? **Please circle yes or no.**

Gastrointestinal Y N Neurological Y N Endocrine Y N

Ear/Nose/Throat Y N Urinary Y N Blood/Lymph Y N

Cardiovascular Y N Muscles/Bones Y N Allergic/Immunologic Y N

Respiratory Y N Skin Y N Headaches Y N

High Blood Pressure Y N Eyes(Medically) Y N Mental/Psychological Y N

Please explain any conditions you circled yes to above:

Diabetes Y N Type: □I □II Date of diagnosis Last A1C

*Medical History continued....*

**Allergies to medications?** Y N If yes what medication? Reaction

Other health problems?

Current Medications

Check if none □

Have you had any operations? Y N Kind & Date?

**Social History**  
Please fill out the following information to the best of your ability. All information is strictly confidential.

*Tobacco Use* *Stopped smoking*

□ None □ Within last year

□ Former smoker □ 1-2 years ago

□ Light smoker, less than 1 pack per day □ 3-4 years ago

□ Average, 1-2 packs per day □ 4-5 years ago

□ Heavy, more than 2 packs per day □ 5+ years ago

□10+ years ago

*Narcotics Use*

*Alcohol Use*

□ None □ None

□ Recreational use □ Social only

□ Chemical dependence □ 1-2 drinks daily

□ Above average

□ Alcohol dependence

**Insurance Information**

**Medical Insurance**

Insurance Carrier: ID Number:

Subscriber Name: Relationship to Patient:

Subscriber Date of Birth: Employer:

**Vision Insurance**

Insurance Carrier: ID Number:

Subscriber Name: Relationship to Patient:

Subscriber Date of Birth: Employer:

I hereby authorize any necessary medical treatment by the optometrist in the practice of Belleville Vision Center or VisionPro Eyecare and agree to be responsible for my bill and any collection fees made necessary to collect payment of services rendered. I authorize this office to release any information necessary to expedite insurance claims. I further authorize the office of Belleville Vision Center or VisionPro Eyecare to release or obtain any required medical information from my attending physicians or any medical facility.

Print Patient Name Signature (Parent or responsible member if minor)

Responsible member if minor Date \_

Hippa Privacy Practice acknowledgement

**I have or was offered and declined a notice of privacy practices.**

**Signature : Date**