Talamo Laser Eye Consultants

Patient Questionnaire

Patient Name _____ ☐ Male ☐ Female
Street Address _____
City _____ Company Name _____ Birth Date _____
State _____ Title _____ SS # _____
Zip _____ Occupation _____ Email _____
Home Phone _____ Work Phone _____ Cell Phone _____
Who should we contact in case of emergency? _____
Phone Number _____ Relationship to Patient _____

How did you hear about us?

☐ MD (specify below)
☐ OD (specify below)
☐ Friend/Family (specify below)
☐ Patient (specify below)
☐ Internet
☐ Magazine
☐ Newspaper
☐ Radio
☐ Television
☐ Yellow Pages
☐ Other:
☐ _____

Name: _____
Hobbies/Interests: _____
Do you have a regular eye doctor? ☐ No ☐ Yes Name: _____ Date of Last Exam: _____
What is your present ocular condition? ☐ Nearsighted ☐ Farsighted ☐ Astigmatism
Do you wear glasses ☐ No ☐ Yes How long? _____
Have you worn contact lenses? ☐ No ☐ Yes How long? _____
What type of contact lenses do you wear? ☐ Soft ☐ Hard ☐ Gas Permeable ☐ Torics

Have you ever had the following: (check all that apply)

Y	N		Y	N		Y	N	
☐	☐	Anemia	☐	☐	Fainting Spells	Are you allergic to:		
☐	☐	Arthritis	☐	☐	Headaches (severe)	☐	☐	Adhesive Tape
☐	☐	Back Problems	☐	☐	Heart Problems:	☐	☐	Latex
☐	☐	Blood Clots/Phebitis			_____	☐	☐	Shellfish/Iodine
☐	☐	Cancer:	☐	☐	Hepatitis	Do you:		
		_____	☐	☐	Herpes	☐	☐	Drink Alcohol
☐	☐	Cold Sores	☐	☐	High Blood Pressure	How much: _____		
☐	☐	Contact with persons	☐	☐	Kidney Disease	☐	☐	Smoke
		who are HIV positive?	☐	☐	Lung Problems:	How much: _____		
☐	☐	Convulsions			_____	**Females, Are you:**		
☐	☐	Diabetes	☐	☐	Neck Problems	☐	☐	Pregnant
☐	☐	Dry Eyes	☐	☐	Pink Eye	☐	☐	Nursing
☐	☐	Excessive Bleeding	☐	☐	Stroke/Paralysis	☐	☐	Trying to get pregnant within the next 6 months

List all illnesses, diseases, conditions or surgeries you may have: _____
_____
List all drug allergies: _____
Have you had problems with anesthesia (explain): _____
List all medication you are currently taking: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Patients Signature _____ Date: _____