Dr. Walter S. Ramsey 1301 Lee Street, East Charleston, WV 25301

Welcome To Our Office

We Thank You For Choosing Our Office To Care For You

Patient Information **Please Print**

Mrs. Ms. Miss Mr. Dr. (Please Circle)

Patient's Name:_____ Nickname:_____

Address: _____City: _____ State: _____ Zip: _____

Home Phone#: _____ Business Phone#: _____E-Mail Address: _____

Patient Social Security number: _____ Birth Date: _____

Emergency Contact Name and Phone #: _____

Race: American Indian Asian Black or African American White Other Decline (Please Circle)

Minor Married Divorced Widowed Single Separated Other (Please Circle)

Employer: _____ Occupation: _____

Student (Y) _____ (N) _____ Grade: _____ School: _____

Spouse's or parent's name: _____ Employer: _____Work#: _____

How or by whom were you referred to our Office: _____

Family Physician/Pediatrician Name: _____

Family Members and Ages: _____

Hobbies of Patient: _____

Responsible Party

Guarantor/Name of Person responsible for this account: _____

Relationship of Guarantor to Patient: Self Parent Other(Specify) _____ (Please Circle)

Address (if different from Patient): _____

Name of Employer: _____ Business phone#: _____

Insurance Information

Are You Covered by Medicare?_____ Is it your Primary Insurance? Yes No (Please Circle)

Do You have Vision Insurance Coverage? Yes No (Please Circle) Name of Company: _____
Name of Policy Holder _____ Relationship to Patient: _____

Do You have Medical Insurance Coverage? Yes No (Please Circle) Name of Company: _____
Name of Policy Holder _____ Relationship to Patient: _____

Authorization

I certify that I have read and understand the information on the front and back of this questionnaire and have answered the questions accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand and agree to be financially responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of Patient (Or parent if a minor) Date

PLEASE COMPLETE INFORMATION ON BACK

Health History Questionnaire

Please describe any concern or problem you have with your eyes:

_____

_____

_____

Do you wear: □glasses?
□ contact lenses? □ hard? □ soft?
For: □ reading? □ distant?

Date of last exam_____
□ Dr. Ramsey □ Dr. Hosman
Other Doctor?_____

Please check any of the problems you have with your vision:

□ poor vision
□ double vision
□ blurred vision
□ poor night vision
□ halos around lights
□ see flashes of light
□ spots before your eyes
□ trouble identifying colors
□ color blindness
□ headaches
□ other (please explain)
_____
_____
_____

Please check any of the problems you have with your eyes:

□ red or bloodshot
□ itching, burning
□ eyes water a lot
□ pain in eyes
□ discharge, like pus
□ sensitive to light
□ gritty sensation
□ other (please describe)
_____
_____
_____

Please check or describe problems with your lids:

□ eyelids itch or burn
□ granulation – stick together in a.m.
□ red, swollen eyelids

Have you had problems such as crossed eyes or eyes that turn out? □ Yes □ No

Have you had any eye injury? □ Yes □ No
If yes, □ Right □ Left

_____

_____

_____

List all medications you are currently taking, including birth control pills and medications you can buy without a prescription (include vitamins taken regularly).

_____

_____

_____

_____

Please give the following information for the last three times you have been hospitalized. Do not list normal pregnancies. (within the last 10 years)
REASON FOR HOSPITALIZATION MONTH/YEAR

_____

_____

_____

_____

List anything you are allergic to, including medicines.

_____

_____

Please indicate if you or any bloods relative have had any of the following conditions:

You	Relative	
□	□	arthritis-when_____
□	□	blood disease-when_____
□	□	cancer/tumor-when_____
□	□	diabetes-when_____
□	□	heart trouble-when_____
□	□	hypertension-when_____
□	□	glaucoma-when_____
□	□	skin infection-when_____
□	□	shingles-when_____
□	□	HIV Positive-when_____
□	□	cataracts-when_____
□	□	other (please name)

_____

Are you light sensitive?_____

Do you have trouble with glare in night driving?____

Do you wear glasses that protect your eyes from UV rays?_____

Are you interested in trying contact lenses?____

Thank you for completing our questionnaire