



# PATIENT HISTORY QUESTIONNAIRE

**IMPORTANT:** This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M/F \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Emergency Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Date of Last Eye Exam \_\_\_\_\_ Dilated? Yes / No Email: \_\_\_\_\_  
 Primary Vision Coverage \_\_\_\_\_ Members Social \_\_\_\_\_

## Medical Information

What is your general health? \_\_\_\_\_

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

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain: \_\_\_\_\_

Diabetes Yes/No Type \_\_\_\_\_ Date of diagnosis \_\_\_\_\_

Allergies to Medication Yes/No Which? \_\_\_\_\_ Reactions? \_\_\_\_\_

Other health problems \_\_\_\_\_

Current medication(s) \_\_\_\_\_

Have you had any operations? Yes/No Kind? \_\_\_\_\_ When? \_\_\_\_\_

Name of family doctor \_\_\_\_\_

Date of last visit \_\_\_\_\_ Date of last tetanus shot \_\_\_\_\_

## Family History

High blood pressure Yes/No Relation \_\_\_\_\_ Macular degeneration Yes/No Relation \_\_\_\_\_

Diabetes Yes/No Relation \_\_\_\_\_ Retinal detachment Yes/No Relation \_\_\_\_\_

Glaucoma Yes/No Relation \_\_\_\_\_ Cataracts Yes/No Relation \_\_\_\_\_

## Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? \_\_\_\_\_

Have you had any eye operations? Yes/No Type \_\_\_\_\_ Date \_\_\_\_\_

Have you had an eye injury? Yes/No Kind \_\_\_\_\_ Date \_\_\_\_\_

Do you have glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No

Macular degeneration? Yes/No Retinal detachment? Yes/No Blurred vision? Yes/No

Do you wear glasses? Yes/No Contact lenses? Yes/No Type \_\_\_\_\_

Additional information \_\_\_\_\_

## Doctor Use Only

Reviewed by \_\_\_\_\_  No changes Date \_\_\_\_\_

Reviewed by \_\_\_\_\_  No changes Date \_\_\_\_\_

Reviewed by \_\_\_\_\_  No changes Date \_\_\_\_\_

***McHENRY OPTICAL, INC***

**DR. SADOFSKY**

**Optometrist**

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**4005 W. Kane Ave.  
McHenry, Illinois 60050  
(815) 385-9240**

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

The undersigned Patient or legally authorized representative (“Agent”) of the Patient acknowledges that he or she personally received a copy of the McHenry Optical’s Notice of Privacy Practices on the date indicated below.

Patient’s Name (Please Print): \_\_\_\_\_

Patient’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Information about Agent

Agent (Print Name): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

## **McHENRY OPTICAL, INC.**

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McHenry, IL 60050  
(815) 385-9240

### **Glasses Selection Acknowledgment**

We are committed to helping you find the best eyewear for your needs and style. It is crucial that you are entirely satisfied with your frame selection, fit, and comfort before finalizing your purchase. Our staff is here to assist you in making an informed decision by providing guidance and answering any questions you may have regarding our range of frames and lenses.

### **Policy Agreement**

I acknowledge and understand that once I have ordered glasses from McHenry Optical I am not eligible to exchange them for a different pair due to dissatisfaction with the style, fit, or comfort level; however, we understand that adjustments to your vision prescription may be necessary. To support your vision health, we offer a 90-day warranty, as provided by your insurance, covering any changes to your prescription lenses recommended by your doctor within this period. Our goal is to ensure that your eyewear not only meets your stylistic preferences but, most importantly, enhances your visual clarity and comfort. This policy is in accordance with the insurance guidelines and the store policy that does not permit exchanges or returns on custom medical devices.

I understand the importance of selecting eyewear that not only meets my visual needs but also my personal comfort and style preferences. By signing below, I agree to the terms outlined above and confirm my understanding that **no exchanges or refunds** will be permitted once glasses have been ordered.

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Patient Signature

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Date