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2813 University Blvd. West
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Pre-Examination Questionnaire

Name_____ Date_____
DOB_____Social Security No._____
Address_____
City_____State_____Zip Code_____
Age_____ Sex_____ Occupation_____
Home Phone_____
Work_____
Cell_____
E-mail_____
Insurance_____
Medicare No._____
Secondary Insurer_____
Referred By_____
Spouse/Parent_____

Reason for today's visit:_____
_____
_____
onset:_____
location:_____
duration:_____
severity:_____
Does anything give relief from symptoms?_____
Is there a pattern of symptoms?_____
Circle all that apply: pain redness discharge itching burning tearing
injury floaters flashes sensitivity to light
other_____
Please list all **medications** and **supplements** you are taking:_____
_____
_____
_____

Please list all **allergies**, systemic and topical_____
_____
_____
_____