PATIENT HISTORY QUESTIONNAIRE

Today's Date _____

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

Last Name _____First Name _____ MI _____
Address _____ City_____ State_____ Zip_____
Work Phone_____Home Phone_____
Date of Birth_____ Occupation_____ Employer _____
Emergency Contact Name _____Phone Number_____
Date of Last Eye Exam _____ Dilated? Yes/No Referred By_____
Primary Vision Coverage _____ Secondary Coverage _____

Medical Information

How is your general health? _____
Do you take medications for 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 and/or primary care physician _____
Date of last visit _____ Date your blood pressure was last checked _____

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_____
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