PATIENT HISTORY QUESTIONNAIRE

Today's Date _____

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

Patient Information

Last Name _____First Name _____ MI _____
Address _____ City_____ State_____ Zip_____
Cell Phone: _____Home Phone_____
Email address: _____
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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