PATIENT HISTORY QUESTIONNAIRE

Today's Date ____________

Last Name ____________ First Name ____________ MI ______

Address ____________ City ____________ State ______ Zip ______

Home Phone ____________ Work ____________ Cell ____________

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 ____________

ID/Social Security # ____________ ID/Social Security # ____________

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	Muscle/Bone	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	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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