

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 _____
 Cellular 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 _____
 Reviewed by _____ No changes Date _____
 Reviewed by _____ No changes Date _____