

Patient History Questionnaire

Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Telephone Home _____ Work _____ Cell _____
SSN _____ Date of Birth _____
Occupation _____ Employer _____
Emergency Contact/ Telephone _____
Date of last eye exam _____ Name of Doctor _____
Name of Vision Insurance _____ Policy ID# _____

Medical Information

Do you have problems with any of these systems? (please circle all that apply)

Gastrointestinal	Y/N	Nervous	Y/N	Blood/lymph	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine (glands)	Y/N
Respiratory	Y/N	Integumentary (Skin)	Y/N	Allergic/Immunology	Y/N

Please answer all that apply:

Diabetes Y/N Type _____ Date of Diagnosis _____
High Blood Pressure Y/N Stable Y/N Date of Diagnosis _____
Medication Allergies _____ What happens? _____
Allergies Y/N To What? _____ What happens? _____
Women: Pregnant? Y/N How Far Along _____ Breast feeding? Y/N
Other health problems _____
Current medication(s) _____
Have you had any operations? Y/N Kind? _____ When? _____
Name of family doctor _____ Last Visit _____
Do you use cigarettes/tobacco? _____ Alcohol? _____ Other Substances _____

Personal Eye Information

Have you had any eye operations? Y/N Type _____ Date _____
Have you had an eye injury? Y/N Kind _____
Do you have glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Blurred Vision? Y/N
Do you wear glasses? Y/N Contact Lenses? Y/N Type _____

Family History

High Blood Pressure Y/N Relation _____ Macular Degeneration Y/N Relation _____
Diabetes Y/N Relation _____ Retinal Detachment Y/N Relation _____
Glaucoma Y/N Relation _____ Cataracts Y/N Relation _____
Other eye condition(s) Y/N What kind? _____ Relation _____
Whom may we thank for referring you? _____
Patient Signature _____ Date _____
Doctor's Initials _____

