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_____ Emergency Contact Name_____
City, State, Zip_____ Phone (_____)_____
Work Phone (_____)_____ Date of Last Eye Exam_____
Home Phone (_____)_____ Dilated? ☐ Yes ☐ No
Email Address _____ Referred By_____
Date of Birth_____ Primary Vision Coverage_____
Occupation_____ Secondary Coverage_____
Employer_____

MEDICAL INFORMATION

How is your general health?_____
Do you take medications for any of these systems? (Please check Yes or No boxes.)

Gastrointestinal	☐Yes ☐No	Nervous	☐Yes ☐No	Endocrine	☐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 medications_____
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 any 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_____