Today's Date: _____

PATIENT HISTORY QUESTIONNAIRE

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

Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Work 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

What is your general health? _____
Do you have problems with 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 _____
Date of last visit _____ Date of last tetanus shot _____

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 _____