



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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocrine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ears/Nose Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood/Lymph	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscles/Bones	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergic/Immunologic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory	<input type="checkbox"/> Yes <input type="checkbox"/> No	Integumentary(skin)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental	<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____

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