

PATIENT HISTORY QUESTIONNAIRE

Last name _____ First name _____ MI _____
Address _____ City _____ State _____ Zip _____
Telephone (Home) _____ (Work) _____
SSN _____ Date of birth _____
Occupation _____ Employer _____
Spouse (or parents) name(s) _____
Date of last eye exam _____ Dilated? _____ Today's date _____

MEDICAL INFORMATION

What is your general health? _____

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

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	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	Blood/Lymph	Y/N
				Allergic/Immunologic	Y/N

Please explain _____

Please answer all that apply:

Diabetes Y/N Type _____ Date of diagnosis _____

Allergies Y/N Allergic to what? _____ What happens? _____

Medication allergy Y/N What happens? _____ Headaches Y/N

Other health problems _____

Current medication(s) _____

Have you had any operations? Y/N Kind? _____ When? _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substance(s)? _____

Name of family doctor _____ Date of last visit _____

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 _____

PERSONAL EYE INFORMATION

Have you had any eye operations? Y/N Type _____ Date _____

Have you had any eye injury? Y/N Kind _____ Date _____

Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred vision? Y/N

Other eye problems? Y/N What kind _____

Do you wear glasses? Y/N Contact lenses? Y/N Type _____

What is the major purpose of this visit? _____

Whom may we thank for referring you? _____

Doctor's initials _____

Patient History
QUESTIONNAIRE