Patient History Questionnaire

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Today's Date _____ Referred By _____
Patient Name _____ E-Mail Address _____
Street Address _____
City, State, and Zip Code _____
Home Phone: ( ) _____ Cell Phone: ( ) _____
Age _____ Birth date _____
Driver's License # _____ Sex ___ Single ___ Married ___ Other ___
Occupation _____ Social Security No. _____
Employer _____ Work Phone ( ) _____
Work Address _____
Primary Vision Coverage _____ Policy/Group # _____
Insured's Name (if diff) _____ Insured's SS # _____
Insured's Birth date _____ Insured's Employer _____
What is your general health? _____
Do you have problems with any of these symptoms? (Please circle **Y**es or **N**o.)

Gastrointestinal	Y/N	Nervous	Y/N	Endocrine (glands)	Y/N
Urinary	Y/N	Ears/Nose/Throat	Y/N	Blood/Lymph	Y/N
Cardiovascular	Y/N	Muscles/bones	Y/N	Allergic/Immunologic	Y/N
Respiratory	Y/N	Integumentary	Y/N	Headaches	Y/N
High Blood Pressure	Y/N	Eyes	Y/N	Mental	Y/N

Please Explain _____
Diabetes Yes/No Type _____ Date of Diagnosis _____
Medications: _____
Allergies: _____
Have you had any operations? Yes/No Kind? _____ When? _____
Name of Family Doctor _____ Date of last Physical _____
Family Doctor Phone ( ) _____ Date of last tetanus shot _____
Family History: (Please circle **Y**es or **N**o.)

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: _____

Eye History: (Please circle **Y**es or **N**o.) Date of last Eye Exam _____

Glaucoma	Y/N	Cataracts	Y/N	Dry eyes	Y/N
Macular degeneration	Y/N	Retinal Detachment	Y/N	Blurred vision	Y/N
Do you wear glasses	Y/N	Do you wear contacts	Y/N	Type of Contacts	_____

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 Type _____ Date _____

Additional Information _____

Responsible Party's Signature _____