

PATIENT HISTORY QUESTIONNAIRE

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

Last name _____ First name _____ MI _____
 Parent/Guardian _____
 Address _____ City _____ State _____ Zip _____
 Home phone (____) _____ Cell phone (____) _____
 DOB _____ SSN _____
 Occupation _____ Employer _____ Work phone (____) _____
 Emergency contact name _____ Phone number (____) _____
 Date of last eye exam _____ Dilated? Yes/No _____ Referred by _____

Medical Information

Do you have problems with any of these systems? **(Please circle yes or no)**

Gastrointestinal	Yes/No	Neurological	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/Migraines	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Psychiatric	Yes/No

Please explain _____
 Diabetes Yes/No _____ Date of Diagnosis _____ Treatment (circle): Insulin Oral Diet
 Allergies to medications? Yes/No Which? _____
 Other health problems _____
 Medications currently taken (receptionist can photocopy lists if desired) _____
 _____ Check if none

Name of family doctor _____ Date of last visit _____
 Are you currently pregnant or breastfeeding? Yes/No _____
 Do you smoke? Yes/No _____ Have you ever been exposed to or infected with (circle): HIV Syphilis Chlamydia Hepatitis
 Have you had any operations? Yes/No Kind? _____

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 (s) _____
 Have you had an eye injury? Yes/No Kind _____ Date (s) _____
 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 _____
 Additional information _____

Signature _____	Date _____	Signature _____	Date _____
Signature _____	Date _____	Signature _____	Date _____
Signature _____	Date _____	Signature _____	Date _____