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? ________________ Referred By: ________________

Primary Vision Coverage ________________ Secondary Coverage ________________

Medical Information

What is your general health? ________________

Do you have problems with any of these systems?

	Yes	No		Yes	No		Yes	No
Gastrointestinal			Nervous			Endocrine (glands)		
Ears/Nose/Throat			Urinary			Blood/Lymph		
Cardiovascular			Muscles/Bones			Allergic/Immunologic		
Respiratory			Integumentary (skin)			Headaches		
High Blood Pressure			Eyes			Mental		

Please explain ________________

Diabetes ________ Type ________________ Date of diagnosis ________________

Allergies to Medication ________ Which? ________________ Reactions? ________________

Other health problems ________________

Current medication(s) ________________

Have you had any operations? ________ Kind? ________________ When? ________________

Name of family doctor ________________

Date of last visit ________________ Date of last tetanus shot ________________

Family History

High blood pressure ______ Relation ________________ Macular degeneration ______ Relation ________________

Diabetes ______ Relation ________________ Retinal detachment ______ Relation ________________

Glaucoma ______ Relation ________________ Cataracts ______ Relation ________________

Personal Eye Information

Do you have any eye conditions or problems? ________ What kind? ________________

Have you had any eye operations? ________ Type ________________ Date ________________

Have you had an eye injury? ________ Kind ________________ Date ________________

Do you have glaucoma? ________ Cataracts? ________ Dry eyes? ________

Macular degeneration? ________ Retinal detachment? ________ Blurred vision? ________

Do you wear glasses? ________ Contact lenses? ________ Type ________________

Additional information ________________

Doctor Use Only

Reviewed by ________________ ___ No changes Date ________________

Reviewed by ________________ ___ No changes Date ________________

Reviewed by ________________ ___ No changes Date ________________

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