Today's Date: ________________

HEALTH HISTORY QUESTIONNAIRE

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

Last Name ________________________________ First Name ________________________ M/F _____ MI _____

Cell Phone ________________________

Date of birth __________________

Date of Last Eye Exam ________________ Dilated? ☐ Yes ☐ No

Medical Information

What is your general health? ____

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

Gastrointestinal	☐ Yes/No ☐	Nervous	☐ 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 ☐	Allergidimmunologic	☐ Yes/No ☐
Respiratory	☐ Yes/No ☐	Integumentary (skin)	☐ Yes/No ☐	Headaches	☐ Yes/No ☐
High Blood Pressure	☐ Yes/No ☐	Eyes	☐ Yes/No ☐	Mental	☐ Yes/No ☐

Please explain ____

Diabetes ☐ Yes/No ☐ Type ______________________________ Date of diagnosis ____________________

Allergies to Medication ☐ Yes/No ☐ Which? ________________________ Reactions? ____________________

Other health problems ____

Current medication(s) ____

Have you had any operations? ☐ Yes/No ☐ Kind? ____________________ When? ____________________

Name of family doctor ____

Date of last visit ____________________________ Date of last tetanus shot ____________________________

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 an 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 ____________________________

Reviewed by ____ ☐ No changes Date ____________________________

Reviewed by ____ ☐ No changes Date ____________________________

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