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 _____ Cell _____

Date of birth _____ Occupation _____ Employer _____

Emergency Contact Name _____ Phone Number _____

Date of Last Eye Exam _____ Dilated? ☐ Yes/No ☐ Referred By: _____

Primary Vision Coverage _____ Member Social Security _____

☐ Male/Female ☐

## Medical Information

What is your general health? _____

Do you have problems with any of these systems? (Please Check 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 ☐ | Allergic/Immunologic | ☐ 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 _____