PATIENT HISTORY QUESTIONNAIRE

(Completion required at each patient appointment)

Last Name _____ First Name _____ Middle Initial ____
Address _____ Unit or Apt. _____
City _____ State _____ Zip _____
Telephone (H) _____ (W) _____ (C) _____
SSN _____ - _____ - _____ Date of Birth _____
Occupation _____
Employer _____
Emergency Contact Name & Relation _____ Number _____
Date of last eye exam _____ Dilated? _____ Today's Date _____
Email address _____

Medical Information

What is your general health? _____

Do you have problems with any of these systems? *(Please circle all that apply.)*

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine (glands)	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Blood/Lymph	Y/N
				Allergic/Immunologic	Y/N

Please explain _____

Please answer all that apply:

Diabetes Y/N Type _____ Date of Diagnosis _____
Allergies Y/N Allergic to what? _____ What happens? _____
Medication allergy Y/N What happens? _____ Headaches Y/N
Other health problems _____
Current medication(s) _____
Have you had any operations? Y/N Kind? _____ When? _____
Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substance(s)? _____
Name of family doctor _____ Date of last visit _____
Date of last tetanus shot _____

Family History

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 _____
Other eye condition(s) Y/N What kind? _____ Relation _____

Personal Eye Information

Have you had any eye operations? Y/N Type _____ Date _____
Have you had an eye injury? Y/N Kind _____ Date _____
Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred vision? Y/N
Other eye problems? Y/N What kind? _____
Do you wear glasses? Y/N Contact lenses? Y/N Type _____
Additional information _____
Whom may we thank for referring you? _____