Patient History Questionnaire

Today's Date ______________ **Email Address** ______________

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

Last Name ______________ First Name ______________ MI ______
Address ______________ City ______________ State______ Zip ______
Mobile Phone ______________ Home Phone ______________ ☐ Male ☐ Female
Date of Birth ______________ Occupation ______________ Employer ______________
Emergency Contact Name ______________ Phone Number ______________
Date of Last Eye Exam ______________ Dilated? Yes/No Referred By ______________
Primary Vision Coverage ______________ Secondary Coverage ______________

Medical Information

How is your general health? ______________
Do you take medications for 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	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 and/or primary care physician ______________
Date of last visit ______________ Date your blood pressure was last checked ______________

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 ______________
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