FOREST PLACE OPTICAL

PATIENT HISTORY QUESTIONNAIRE

Today's Date _____

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

Last Name _____ First Name _____ MI _____

Address _____ Emergency Contact Name _____

City, State, Zip _____ Phone (_____) _____

Cell Phone (_____) _____ Date of Last Eye Exam _____

Home Phone (_____) _____ Dilated? Yes ☐ No ☐

Email Address _____ Referred By _____

Date of Birth _____ Male ☐ Female ☐ Primary Vision Coverage _____

Occupation _____ Secondary Coverage _____

Employer _____

MEDICAL INFORMATION

How is your general health?

Do you take medication for any of these systems? (Please check Yes or No Boxes.)

Gastrointestinal	☐Yes ☐No	Nervous	☐Yes ☐No	Endocrine	☐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 heath problems _____

Current medications _____

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 any 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: _____