Patient History Questionnaire

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Today's Date_____

First Name_____ MI___
Last Name_____
Address_____
City, State, Zip_____
Cell Phone (_____) _____
Work Phone (_____) _____
Home Phone(_____) _____
Email Address_____
Date of Birth_____

Occupation_____
Employer_____
Emergency Contact Name _____
Phone (_____) _____
Date of Last Eye Exam_____
Referred By_____
Type of Vision Insurance_____
Type of Medical Insurance_____
Medicare/Policy Number_____

Reason for Today's Visit_____

MEDICAL INFORMATION

How is your general health?_____
Do you take medications for any of these systems? (Check Yes or No)

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? _____Reaction? _____
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_____

Please Flip and Continue on Back…

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_____

DOCTOR USE ONLY

Reviewed By _____ ☐ No Changes Date_____

Reviewed By _____ ☐ No Changes Date_____

Reviewed By _____ ☐ No Changes Date_____

Reviewed By _____ ☐ No Changes Date_____