

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 _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ E-mail Address: _____

Date of birth _____ Occupation _____ Employer _____

Emergency Contact Name _____ Phone Number _____

Social Security Number: _____ Date of Last Eye Exam _____ Referred By: _____

Primary Vision Coverage _____ Secondary Coverage _____

Medical Information

What is your general health? _____

Do you have problems with 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 Type? _____ When? _____

Name of family doctor _____ Date of last visit _____ Date of last tetanus shot _____

Do you smoke? Yes/No Do you drink alcohol? Yes/No Do you use other substances? _____

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 Type _____ 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 _____

Please Sign and Date this form giving us permission to bill your insurances:

Signature _____ Date: _____

Doctor Use Only

Reviewed by _____ No changes Date _____

Reviewed by _____ No changes Date _____

Reviewed by _____ No changes Date _____

Reviewed by _____ No changes Date _____