Patient History Questionnaire

(Completion or review required at each patient appointment)

Last Name_____First_____MI____Today's Date_____
Date of birth_____Spouse's name(If child,name of parents)_____ _____
Address/City_____
Home phone#_____Cell #_____Work #_____
Soc. Sec. #_____Occupation/Grade of patient_____
Emergency Contact_____ _____Phone# _____
If you carry vision insurance, please list_____
Email_____

Personal Eye Information

Please circle the correct response (yes or no)

Date of last eye exam_____

Do you wear glasses?	Y/N	Do you have double vision?	Y/N
Do you have glaucoma?	Y/N	Do you have macular degeneration?	Y/N
Do you have cataracts?	Y/N	Have you had a retinal detachment?	Y/N
Do you have dry eye?	Y/N	Do you have problems with glare?	Y/N

Do you have other vision problems? Y/N _____
Do you wear contact lenses? Y/N _____
Have you had any injuries to your eyes? Y/N _____
Have you had any eye operations? Y/N _____

Personal Medical Information

What is your general health? Excellent Good Fair Poor

Are you under a doctor's care for any conditions? (some examples are given)

Gastrointestinal (stomach, digestive)	Y/N	Endocrine (thyroid,diabetes)	Y/N	Mental	Y/N
Genitourinary (kidney, bladder, STD)	Y/N	Skin (eczema, psoriasis)	Y/N	Ear/Nose/throat	Y/N
Cardiovascular (heart, h.b.p.)	Y/N	Musculoskeletal (arthritis)	Y/N	Blood(hepatitis)	Y/N
Respiratory (asthma, breathing)	Y/N	Immunologic (AIDS, HIV)	Y/N	Nervous	Y/N

Additional Information _____
If Diabetic, type _____ Date of Diagnosis _____
Do you have any allergies? Y/N Please list _____
Have you had allergic reactions to medicines? Y/N If so, please List _____
Do you use cigarettes/tobacco products Y/N Do you drink alcohol? Y/N
Do you use other substances? Y/N
Name of family physician _____ Date of last visit _____
Medications _____

Family Medical History (grandparents, parents, brothers and sisters)

High Blood Pressure Y/N relation _____		Macular Degeneration	Y/N relation _____
Diabetes Y/N relation _____		Cataracts	Y/N relation _____
Heart Problems Y/N relation _____		Glaucoma	Y/N relation _____
Retinal Detachment Y/N relation _____		Other _____	

Doctor's initials and date _____