PATIENT HISTORY QUESTIONNAIRE

Last name: First name: MI:

Address:

Work Phone:_____ Home:_____ Cell:_____

Date of birth: Sex:

Occupation:_____

Employer or School:_____

Emergency Contact & Telephone:_____

Date of last eye exam: _____ Dilated? Y/N Date:

MEDICAL INFORMATION

What is your general health? _____

Do you have problems with any of these systems? (Please circle Yes or No)

Gastrointestinal	Y/N	Nervous	Y/N	Eyes Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	
Cardiovascular	Y/N	Musculoskeletal	Y/N	
Respiratory	Y/N	Skin	Y/N	
Mental	Y/N	Endocrine(glands)	Y/N	
Blood/lymph	Y/N	Allergic/immune	Y/N	

Please explain _____

Please answer all that apply:

Diabetes Y/N Type _____ Date of diagnosis _____

Allergies Y/N Allergic to what? _____ What happens? _____

Medication allergy Y/N What happens? _____ Headaches Y/N

Other health problems _____

Current medication(s) _____

Have you had any operations? Y/N Kind? _____

When? _____

Do you use cigarettes? Y/N Tobacco? Y/N Alcohol? Y/N

Do you use other substances? Y/N _____

Name of family doctor _____ Date of last visit _____

Date of last tetanus shot _____

Do you have an Advance Directive for health care? (Living will) _____

FAMILY HISTORY (Relationships)

High blood pressure	Y/N Rel_____		Macular degeneration	Y/N Rel_____	
Diabetes	Y/N Rel_____		Retinal detachment	Y/N Rel_____	
Glaucoma	Y/N Rel_____		Cataracts	Y/N Rel_____	
Other eye condition	Y/N What kind?_____			Rel_____	

PERSONAL EYE INFORMATION

Have you had any eye operations? Y/N Type_____ Date_____

Have you had an eye injury? Y/N Kind _____ Date_____

Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N

Do you have blurred vision? Y/N When?_____

Do you wear glasses? Y/N Contact lenses? Y/N Type_____

Additional information _____

Whom may we thank for referring you? _____

Doctor's initials _____