



PATIENT HISTORY QUESTIONNAIRE

(completion required at each patient appointment)

Last name _____ First name _____ MI _____
 Address _____
 Telephone (W) _____ (H) _____
 SSN _____ - _____ - _____ Date of birth _____
 Occupation _____
 Employer _____
 Emergency contact/Telephone Number _____
 Date of last eye exam _____ Dilated? _____ Today's date _____

Medical Information

What is your general health? _____

Do you have problems with any of these systems? (please circle all that apply)

Eyes	Y/N				
Gastrointestinal	Y/N	Nervous	Y/N	Mental	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine (glands)	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/lymph	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Allergic/immunologic	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/tobacco? _____ Alcohol? _____ Other substance(s)? _____
 Name of family doctor _____ Date of last visit _____
 Date of last tetanus shot _____

Family History

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

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 Blurred vision? Y/N
 Other eye problems? Y/N What kind? _____
 Do you wear glasses? Y/N Contact lenses? Y/N Type _____
 Additional information _____
 Whom may we thank for referring you? _____

Doctor's initials _____