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 _____

Home Phone_____ Work Phone_____ Cell_____ Text ok? ☐

Email (For office communication only)_____

Date of birth _____ Referred By:_____

Occupation_____ Employer_____

Date of Last Eye Exam_____ Dilated? Yes / No Where?_____

Primary Vision Coverage _____ Secondary Coverage _____

Parent/Guardian Name (if minor)_____

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 Kind? _____When? _____

Name of family doctor_____

Date of last visit_____ Date of last tetanus shot _____

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 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 _____

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