



PATIENT HISTORY QUESTIONNAIRE

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 (_____) _____ SSN _____
 Birth date _____ Age _____ Occupation _____ Employer _____
 Emergency contact name _____ Phone number (_____) _____
 Date of last eye exam _____ Vision Insurance _____
 Today's date _____ Referred by _____

Medical Information

What is your general health? () Excellent () Good () Fair () Poor
 Do you have problems with any of these systems? (Please circle Yes or No).

Gastrointestinal	Yes / No	Nervous	Yes / No	Endocrine (glands)	Yes / No
Ear/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 Which type? _____ Since? _____ Reactions? _____
 Other health problems _____
 Currents medication(s) _____

Have you had any operations? Yes / No Kind? _____ When? _____
 Name of family doctor _____ Address _____
 _____ Date of last visit _____

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 _____
 Have you ever had your eyes dilated? Yes / No Were they dilated at your last eye exam? Yes / No

Doctor Use Only

Reviewed by _____ **No changes** Date _____
 Reviewed by _____ **No changes** Date _____
 Reviewed by _____ **No changes** Date _____