PATIENT HISTORY QUESTIONNAIRE

Todays date_________________

Last name___________________________First name:_____________________M______________

Address_____________________________City_____________________State_______Zip_________

Home Phone (   )_______________Work Phone (   )__________SS#___________________________

Date of Birth____________Occupation__________________Employer_________________________

Spouse_________________ Parent______________________ Referred by____________________

Date of Last Exam__________________ Dilated yes/no

MEDICAL INFORMATION

VISION INSURANCE? Yes/No Carrier________________________

What is your general health?____

Do you have a problem 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	Skin	yes/no	Allergic/immunological	yes/no
Respiratory	yes/no	Headaches	yes/no	Muscle/bones	yes/no
High Blood pressure	yes/no	Eyes	yes/no	Mental	yes/no

Please explain____

Diabetes yes/no Type__________ Date of diagnosis_____________________________

Allergies to medications? yes/no Which_______________Reaction___________________

Other health problems?____

Current medications____

Have you had any operations? yes/no Kind_________________________When_____________

Name of family doctor______________________________

Date of last visit________________________ 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 any eye injuries? 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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