PATIENT HISTORY QUESTIONNAIRE

Last Name: _____ First Name: _____ Middle Initial: ____
Address: _____
Telephone Cell: _____ Home: _____ Work: _____
SSN: _____ - _____ - _____ Date of Birth: _____ Email: _____
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 _____