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______________

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