PATIENT HISTORY QUESTIONNAIRE

Last Name: ______________________ First Name: ________________ MI: ________________
Address: ____
Work Phone: ______________________ Home: ______________ Cell: ________________
Date of birth: ______________________ Sex: M / F E-mail: ________________________
Occupation: ____
Employer or School: ____
Emergency Contact & Telephone: ____
Date of last eye exam: Dilated? Y / N Date:
Medical Insurance - HMO/PPO/Kaiser or ____

MEDICAL INFORMATION

What is your general health? ____

Do you have problems with any of these systems? (Please circle Yes or No)

Gastrointestinal	Y / N	Nervous	Y / N	Eyes	Y / N
Ears / Nose / Throat	Y / N	Genitourinary	Y / N		
Cardiovascular	Y / N	Musculoskeletal	Y / N		
Respiratory	Y / N	Skin	Y / N		
Mental	Y / N	Endocrine (glands)	Y / N		
Blood / Lymph	Y / N	Allergic / Immune	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 ____
Taking medication (s) Y / N If so what: ____
Have you had any operations? Y/N Kind? ______________________________________
When? ______________________________________
Do you use cigarettes? Y / N Tobacco? Y / N Alcohol? Y / N
Do you use other substances? Y / N ____
Name of Family doctor ______________________ Date of last visit ________________
Date of last tetanus shot ____
Do you have an Advance Directive for health care? (Living will) ____________________

FAMILY HISTORY (Relationships)

High blood pressure	Y / N	Rel ________	Macular degeneration	Y / N	Rel ________
Diabetes	Y / N	Rel ________	Retinal detachment	Y / N	Rel ________
Glaucoma	Y / N	Rel ________	Cataracts	Y / N	Rel ________
Other eye condition	Y / N	What kind? ________			Rel ________

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
Do you have blurred vision? Y/N When? ____
Do you wear glasses? Y / N Contact lenses? Y / N Type ________________________
Additional information ____
Whom may we thank for referring you? ____
Doctor's initials ______________________