



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 _____
 Work Phone _____ Home Phone _____
 Date of birth _____ Occupation _____ Employer _____
 Emergency Contact Name _____ Phone Number _____
 Date of Last Eye Exam _____ Dilated Yes / No Referred By _____
 Primary Vision Coverage _____ Secondary Coverage _____

Medical Information

What is your general health? _____
 Do you have problems 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	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 Type _____ Date of diagnosis _____
 Allergies to Medication Yes / No Which? _____ Reactions? _____
 Other health problems _____
 Current Medication(s) _____
 Have you had any operations? Yes / No Kind? _____ When? _____
 Name of family doctor _____
 Date of last visit _____ Date of 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 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 _____
 Additional Information _____

Doctor Use Only

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