

## PATIENT HISTORY QUESTIONNAIRE

(must be updated at each visit)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Mr/Mrs/Ms/Miss/Dr \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone ( home ) \_\_\_\_\_ ( work ) \_\_\_\_\_  
 SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Married? Y/N \_\_\_\_\_ Spouse's name \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Date of last eye exam \_\_\_\_\_ Dilated? \_\_\_\_\_ Today's date \_\_\_\_\_

### MEDICAL INFORMATION

(please circle all that apply)

How is your general health? \_\_\_\_\_  
 Do you have problems with any of these systems? (please circle all that apply)

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine (glands)	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Blood/lymph	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 substances? \_\_\_\_\_  
 Name of family doctor \_\_\_\_\_ Date of last visit \_\_\_\_\_  
 Date of last tetanus shot \_\_\_\_\_ Are you pregnant? Y N \_\_\_\_\_

### 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 \_\_\_\_\_  
 Reason for Visit (please check) \_\_\_\_\_ Routine exam \_\_\_\_\_ Contact lenses \_\_\_\_\_ New glasses \_\_\_\_\_  
 Other (please explain) \_\_\_\_\_  
 Whom may we thank for referring you? (please circle) \_\_\_\_\_ person ( please state name ) \_\_\_\_\_  
 \_\_\_\_\_ yellow pages \_\_\_\_\_ insurance \_\_\_\_\_  
 E-mail address \_\_\_\_\_  
 Doctor's initials \_\_\_\_\_