

**Patient History Questionnaire**

Today's Date \_\_\_\_\_

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**

How is your general health? \_\_\_\_\_  
 Do you take medications for 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 and/or primary care physician \_\_\_\_\_  
 Date of last visit \_\_\_\_\_ Date your blood pressure was last checked \_\_\_\_\_

**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 \_\_\_\_\_