



# PATIENT HISTORY QUESTIONNAIRE

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

**IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_ Emergency Contact Name \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
 Work Phone (\_\_\_\_\_) \_\_\_\_\_ Date of Last Eye Exam \_\_\_\_\_  
 Home Phone (\_\_\_\_\_) \_\_\_\_\_ Dilated?  Yes  No  
 Email Address \_\_\_\_\_ Referred By \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Primary Vision Coverage \_\_\_\_\_  
 Occupation \_\_\_\_\_ Secondary Coverage \_\_\_\_\_  
 Employer \_\_\_\_\_

### MEDICAL INFORMATION

How is your general health? \_\_\_\_\_  
 Do you take medications for any of these systems? (Please check Yes or No boxes.)  
 Gastrointestinal  Yes  No Nervous  Yes  No Endocrine  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 medications \_\_\_\_\_  
 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 any 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 \_\_\_\_\_