

PATIENT HISTORY QUESTIONNAIRE

Mr. ___ Ms. ___ Mrs. ___ First Name: _____ MI: ___ Last Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: (Home) _____ (Work) _____ (Cell) _____
Social Security Number: _____ - _____ - _____ Date of Birth: _____
Employer: _____ Occupation: _____
Emergency Contact Name/ Number: _____ Date of Last Eye Exam: _____
Reason For Today's Visit: _____ Email: _____

MEDICAL HISTORY

How is your General Health? _____
Do you have any problems with any of these systems? *(Please circle all that apply)*

				Eye	Y / N
Gastrointestinal	Y / N	Nervous	Y / N	Mental	Y / N
Ears/Nose/Throat	Y / N	Genitourinary	Y / N	Endocrine	Y / N
Cardiovascular	Y / N	Musculoskeletal	Y / N	Blood/Lymph	Y / N
Respiratory	Y / N	Integumentary (skin)	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 happens: _____
Medication Allergy Y / N What happens: _____ Headaches Y / N
Other health problems: _____
Current medication (s): _____
Have you had any operations? Y / N What kind? _____ When: _____
Do you use cigarettes/tobacco? Y / N Alcohol Y / N Other substances: _____
Name of family doctor: _____ Date of last visit: _____

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? _____

PERSONAL EYE INFORMATION

Have you had any eye operations? Y / N Type: _____ Date: _____
Have you had any 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 If so, what type? _____
Are you interested in wearing contact lenses? Y / N Additional Information _____
Are you interested in Lasik refractive eye surgery? Y / N
What hobbies or sports do you participate in? _____
Whom may we thank for referring you to us? _____