Patient History Questionnaire

Today's Date _____

IMPORTANT: THIS QUESTIONNAIRE IS TO BE REVIEWED AT EACH APPOINTMENT.
PLEASE ANSWER ALL QUESTIONS! REVIEWING IS REQUIRED BEFORE EACH VISIT.

Last Name _____ First Name _____ M.I. _____ Nickname _____
Address _____ City _____ State _____ Zip _____
Work Phone _____Home Phone _____ Cell Phone _____ E-mail Address _____
Date of Birth _____ Social Security Number_____ Employer _____Gender: Male/Female
Marital status _____ Race _____ Ethnicity _____Emergency Contact Name/Phone Number_____
Date of Last Eye Exam _____ Dilated? Yes/No Rx Change? Yes/No Referred By _____
Primary Vision Coverage _____ Primary/Secondary Medical Coverage _____

RESPONSIBLE PARTY (If patient listed above is not the primary insurance subscriber):
Name: _____ SSN _____ DOB _____

PERSONAL EYE INFORMATION

What is the reason for your visit today? (circle one) **WELLNESS EXAM** **MEDICAL EYE EVALUATION**
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	CL Brand _____	

Additional information _____
_____

PERSONAL 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(S)? Yes/No Which? _____ Reactions? _____
Other health problems _____
CURRENT MEDICATIONS (Please list all): _____
_____
_____
_____
_____
_____
History of surgeries/operations? Yes/No Kind? _____ When? _____
Name of family doctor and/or primary care physician _____Date of last physical?_____
History of HIV+ or Sexually-transmitted diseases? Yes/No Specifics _____
History of Smoking? Yes/No Current/Past How many years smoking?_____ Packs/day_____ Quit smoking when?_____
Alcohol consumption? Yes/No Current/Past Social/1-2 drinks a day/Above avg. consumption/Alcohol dependent
History of Narcotic use? Yes/No Current/Past Drug(s) of choice?_____

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 _____