



PATIENT HISTORY QUESTIONNAIRE

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Please check one: New Patient Returning Patient Appt. Date: _____ Day _____ Appt. Time: _____

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

Last name _____ First name _____ MI _____
 Address _____ City _____ State _____ Zip _____
 Home phone (____) _____ Cell phone (____) _____ Work phone (____) _____
 Name of Vision Insurance _____ Insured's ID # / SS # _____ Name of Medical Insurance _____
 Date of last eye exam _____ Pupils Dilated? Yes / No Reason for visit: Glasses Contact Lens Both
 DOB _____ Occupation _____ Employer _____
 Emergency Contact Name _____ Phone number (____) _____
 Today's date _____ Referred by _____

Medical Information

How is your general health? _____

Do you have problems with any of these systems? **(Please circle yes or no)**

Gastrointestinal	Yes / No	Neurological	Yes / No	Cancer	Yes / No
Ears/Nose/Throat	Yes / No	Urinary	Yes / No	Endocrine	Yes / No
Cardiovascular	Yes / No	Muscles/bones	Yes / No	Blood/lymph	Yes / No
Respiratory	Yes / No	Integumentary (skin)	Yes / No	Allergic/immunologic	Yes / No
High blood pressure	Yes / No	Eyes	Yes / No	Headaches	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) _____ Check if none

Have you ever had any operations? Yes / No What kind? _____ When? _____

Name of family doctor _____ Date of last visit _____

Are you pregnant? Yes / No Are you nursing? Yes / No Date of last tetanus shot _____

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 What 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	Uncomfortable glasses?	Yes / No	Corneal abrasion?	Yes / No
Eye infection?	Yes / No	Iritis/uveitis?	Yes / No	Lazy eye?	Yes / No
Other eye disorders?	Yes / No	Headaches?	Yes / No	Itchiness?	Yes / No
Burning?	Yes / No	Double vision?	Yes / No	Grittiness?	Yes / No
Tearing?	Yes / No	Trouble seeing at night?	Yes / No	Flash of light?	Yes / No
Sunlight sensitivity?	Yes / No	Crossed eye/eye turn?	Yes / No	Floater/spots?	Yes / No

Additional information _____