PATIENT HISTORY QUESTIONNAIRE

Last Name _____ First Name _____ MI____

Address _____ City _____ Zip _____

Home Phone_____ Cell Phone _____ Work Phone_____

Date of Birth _____ Occupation _____ Employer_____

Social Security # _____ Sex M/F Spouse's Name_____

Date of Last Eye Exam _____ Referred By: _____

Vision Insurance_____ Health Insurance _____

Policy Holder Name_____**DOB**_____**ID#**_____

Employer_____**Social Security #**_____

Email _____

MEDICAL INFORMATION

Do you have problems with any of these systems? **(Please circle Y or N.)**

Gastrointestinal	Y/N	Nervous	Y/N	Endocrine	Y/N
Cardiovascular	Y/N	Muscles/Bones	Y/N	Blood/Lymph	Y/N
Respiratory	Y/N	Integumentary (Skin)	Y/N	Allergic/Immunologic	Y/N
High Blood Pressure	Y/N	Eyes	Y/N	Headaches	Y/N

Please explain _____
Diabetes Yes/No Type _____ Date of diagnosis _____
Medication allergies Yes/No Which? _____
Current medication(s) _____
Name of family doctor _____ Date of last visit _____

FAMILY HISTORY

High blood pressure Y/N Who?_____ Heart disease Y/N Who?_____
Diabetes Y/N Who? _____ Retina disease Y/N Who?_____
Glaucoma Y/N Who? _____ Cataracts Y/N Who?_____
Macular degeneration Y/N Who?_____

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? Y/N What kind? _____
Have you had any eye operations? Y/N Type_____Date _____
Have you had an eye injury? Y/N Kind _____ Date _____
Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Floaters? Y/N
Light flashes? Y/N Macular degeneration? Y/N Blurred vision? Y/N
Do you wear glasses? Y/N Contact lenses? Y/N Type _____