Patient History Questionnaire

Today's Date _____

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

Last Name _____ First Name _____ Male/Female

Address _____ City _____ State _____ Zip Code _____

Email: _____ Cell Phone: _____

Date of Birth _____ Occupation _____ Employer _____

Emergency Contact Name _____ Phone Number _____

Date of Last Eye Exam _____ Dilated? Yes/No Referred By _____

Primary Vision Coverage _____ Person insurance is under? _____

Medical Information

How is your general health? _____

Do you have any of the following? **(Please circle yes or no)**.

High Blood Pressure Yes/No Diabetes Yes/No Diabetes type? _____ Date of diagnosis _____

High Cholesterol Yes/No Heart Disease Yes/No Asthma Yes/No

Allergies Yes/No Thyroid Disorder Yes/No Migraines Yes/No

Other (please specify): _____

Allergies to medication Yes/No Which? _____ Reactions? _____

Current medication(s) _____

Have you had any operations? Yes/No Kind? _____ Date _____

Name of family doctor and/or primary care physician _____ Date of last visit _____

Family History

High Blood Pressure Yes/No Relation _____ Macular Degeneration Yes/No Relation _____

High Cholesterol Yes/No Relation _____ Glaucoma Yes/No Relation _____

Diabetes Yes/No Relation _____ Retinal Detachment Yes/No Relation _____

Personal Eye Information

Do you have any eye conditions? Yes/No What kind? _____

Have you had any eye operations? Yes/No Type _____ Date _____

Have you had any eye injury? Yes/No Type _____ 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 _____

Doctor Use Only

Reviewed by _____ ○ No Changes Date _____

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