PATIENT HISTORY QUESTIONNAIRE

Date:________________ email:______________________________

☐ MARRIED ☐ SINGLE

Last Name_________________________ First Name________________________MI __________ ☐ SEPARATE/DIVORCED

Street/Box #___________________________City_________________________Zip_________Date of Birth_______________

Phone (h)__________________(w)_____________________cell#_____________________ SSN(last 4 digit)________________

Parents Name (if minor) Mother___________________________________Father__________________________________

Phone (h)__________________(w)_____________________cell#_____________________ SSN(last 4 digit)________________

Occupation______________________________Employer____

Emergency Contact____Phone________________________________

Vision Insurance:_______________________________________ Insured's Name__________________________________

Preferred spoken/written language?____

Purpose of today's visit: ☐ Routine ☐ Glasses ☐ Contact Lenses ☐ Laser Surgery ☐ Other
Method of Payment: ☐ Cash ☐ Credit Card ☐ Debit Card ☐ Check

MEDICAL INFORMATION

How is your general health?____

Do you have problems with any of these systems? *(please circle all that apply)*

Gastrointestinal	Y/N	Nervous	Y/N	Mental	Y/N	Ear/Nose/Throat	Y/N
Genitourinary	Y/N	Blood/Lymph	Y/N	Cardiovascular	Y/N	Musculoskeletal	Y/N
Allergic/immunologic	Y/N	Respiratory	Y/N	Skin	Y/N		

Please explain____

Please answer all that apply:

Diabetes Y/N Type____Date of diagnosis______________

Allergies Y/N Allergic to what?__________________________________What happens?____________________

Medication allergy Y/N What happens?____Headaches Y/N

Other health problems____

Current medication(s)____

Have you had any operations? Y/N Kind?____ When__________________

Do you use cigarettes/tobacco?_____________ Alcohol?_____________Other substance(s)?_________________________

Name of family doctor____ Date of last tetanus shot?____________________

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 condition(s)	Y/N What kind?____				Relation______________

PERSONAL EYE INFORMATION

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 Blurred vision Y/N

Other eye problems? Y/N What kind?____

Do you wear glasses? Y/N Contact lenses Y/N Type?____

Whom may we thank for referring you?____

Reviewed: Date:_____________Doctor's initials_____________

Changes since last exam: ☐None Dr's initials