PATIENT HISTORY QUESTIONNAIRE

(must be updated at each visit)

Last name_____ First name_____ MI_____

Address_____

Telephone (W)_____ (H)_____

_____-_____-_____ Date of birth_____

Occupation_____

Employer_____

Emergency contact/Telephone no._____

Date of last eye exam_____ Dilated?_____ Today's date_____

MEDICAL INFORMATION

What is your general health?_____

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

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine (glands)	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Blood/lymph	Y/N
				Allergic/immunologic	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 visit_____

Date of last tetanus shot_____

Do you have an Advance Directive for health care? _____

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 eye 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_____

Additional information_____

Whom may we thank for referring you?_____

Doctor's initials_____