Patient History Questionnaire

(Completion or review required at each patient appointment)

Last Name___________________ First Name_________________MI___Today's date____________________
Date of birth____________________ Spouse's Name (if a child, parents' names) ______________________
Address____
Telephone Number Home _____________________ Work ____
Social Security Number ______-____-__________ Patient's occupation or grade______________________
If you have vision insurance, please list ____

Please circle the correct response (yes or no)

Personal Eye Information

Date of last eye exam________________________

Do you wear glasses? Y/N
Do you have glaucoma? Y/N
Do you have cataracts? Y/N
Do you have dry eye? Y/N
Do you have double vision? Y/N
Do you have macular degeneration? Y/N
Have you had a retinal detachment? Y/N
Do you have problems with glare? Y/N
Do you have other vision problems? Y/N ____
Do you wear contact lenses? Y/N ____
Have you had any injuries to your eyes? Y/N ____
Have you had any eye operations? Y/N ____

Personal Medical Information

What is your general health? Excellent Good Fair Poor
Are you under a doctor's care for any of these conditions? (some examples are given)

Gastrointestinal (stomach, digestive) Y/N
Genitourinary (kidney, bladder, STD) Y/N
Cardiovascular (heart, h.b.p.) Y/N
Respiratory (asthma, breathing) Y/N
Endocrine (thyroid, diabetes) Y/N
Skin (eczema, psoriasis) Y/N
Musculoskeletal (arthritis) Y/N
Immunologic (AIDS, HIV) Y/N
Mental Y/N
Ears/nose/throat Y/N
Blood (hepatitis) Y/N
Nervous Y/N

Additional information____
If diabetic, type________________________ Date of diagnosis ____________________________
Do you have any allergies? Y/N Please list ________________________________
Have you had any allergic reactions to medicines? Y/N If yes, please list ____________________________
Do you use cigarettes/tobacco products? Y/N Do you drink alcohol? Y/N
Do you use other substances? Y/N

Name of family doctor__________________________________ Date of last visit_______________________
Medications (including any eye drops) ____

Family Medical History (for example parents, brothers or sisters)

High blood pressure Y/N relation____________
Diabetes Y/N relation____________
Heart problems Y/N relation____________
Retinal detachment Y/N relation____________
Macular degeneration Y/N relation___________
Cataracts Y/N relation___________
Glaucoma Y/N relation___________
Other ____

Doctor's initials and date____