

P A T I E N T H I S T O R Y Q U E S T I O N N A I R E

Last name: _____ First name: _____ MI: _____
 Address: _____
 Work Phone: _____ Home: _____ Cell: _____
 Date of birth: _____ Sex: _____
 Occupation: _____
 Employer or School: _____
 Emergency Contact & Telephone: _____
 Date of last eye exam: _____ Dilated? Y/N _____ Date: _____

M E D I C A L I N F O R M A T I O N

What is your general health? _____
Do you have problems with any of these systems? (Please circle Yes or No)
 Gastrointestinal Y/N Nervous Y/N Eyes Y/N
 Ears/Nose/Throat Y/N Genitourinary Y/N
 Cardiovascular Y/N Musculoskeletal Y/N
 Respiratory Y/N Skin Y/N
 Mental Y/N Endocrine (glands) Y/N
 Blood/lymph Y/N Allergic/immune 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? Y/N Tobacco? Y/N Alcohol? Y/N
 Do you use other substances? Y/N _____
 Name of family doctor _____ Date of last visit _____
 Date of last tetanus shot _____
 Do you have an Advance Directive for health care? (Living will) _____

F A M I L Y H I S T O R Y (Relationships)

High blood pressure Y/N Rel _____ Macular degeneration Y/N Rel _____
 Diabetes Y/N Rel _____ Retinal detachment Y/N Rel _____
 Glaucoma Y/N Rel _____ Cataracts Y/N Rel _____
 Other eye condition Y/N What kind? _____ Rel _____

P E R S O N A L E Y E I N F O R M A T I O N

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
 Do you have blurred vision? Y/N When? _____
 Do you wear glasses? Y/N Contact lenses? Y/N Type _____
 Additional information _____
 Whom may we thank for referring you? _____
 Doctor's initials _____