PATIENT HISTORY QUESTIONNAIRE

Last name ________________________________ First name ____________________________ MI________

Address____ City_____________________ Zip_____________

Telephone (Home)___________________ (work)_______________________ (cell)_______________________

SSN____ Date of birth _________________ M ___F________

Occupation_____________________________ Employer____

Emergency contact person/number____

Date of last eye exam______________________ Eyes dilated? Y / N Today's date________________________

MEDICAL INFORMATION

What is your general health? ____

Circle any of these systems that you have had with problems with:

Eyes	Gastrointestinal	Nervous	Mental	Ears/Nose/Throat
Genitourinary	Endocrine (glands)	Cardiovascular		Musculoskeletal
Blood/Lymph	Respiratory	Integumentary (skin)		Allergic/Immunological

Please explain____

Please answer all that apply:

Diabetes Y/N Type ____ Date of diagnosis_____________

Allergies Y/N Allergic to what? ______________________ What happens? ______________________________

Medication allergies? Y/N What happens?____

Other health problems?____ Headaches? Y/N

Current medications____

Surgeries____ When?________________________

Do you use cigarettes? _________ Tobacco? ______ Alcohol? _______ Other substances?___________________

Family Dr _______________________ Date of last visit _____________ Date of last Tetanus shot_____________

Insurance Company ______________________________ Supplemental Ins? ____________________________

FAMILY HISTORY

Circle any that apply to family members:

High blood pressure Macular degeneration Diabetes Retinal detachment Glaucoma

Cataracts Other eye conditions____

PERSONAL EYE INFORMATION

Eye operations? Y/N What?____ When?_____________________

Eye injury? Y/N What?____ When?___________________

Do you have: Glaucoma Y/N Cataracts Y/N Dry eyes Y/N Blurry vision Y/N Other________________

Do you wear glasses? Y/N Contact lenses? Y/N Type____

LIFESTYLE

What activities do you enjoy? Circle all that apply.

Golf Biking Woodworking/Carpentry Boating Tennis Computer Fishing Running TV Sewing Walking Hunting Driving Reading Playing Cards Aerobics Movies Cooking Bowling Soccer Basketball Football Dining out Camping Skiing Dancing Hiking Music Singing Performing music Playing piano Swimming

Whom may we thank for referring you? ____