

# PATIENT HISTORY QUESTIONNAIRE

Please complete the following. If you have any questions, we would be happy to assist you.

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (H) \_\_\_\_\_ (Day) \_\_\_\_\_ Email \_\_\_\_\_  
Insured Party's: Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Ins. ID No. \_\_\_\_\_  
Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Emergency contact & telephone number \_\_\_\_\_  
Date of last eye exam \_\_\_\_\_ Were you dilated? \_\_\_\_\_ Today's date \_\_\_\_\_  
Referred by \_\_\_\_\_ Name of Primary Care Physician \_\_\_\_\_

## MEDICAL INFORMATION

What is your general health? \_\_\_\_\_

Do you have problems with any of these systems? Eyes Y/N

Gastrointestinal Y/N Nervous Y/N Mental Y/N

Ears/Nose/Throat Y/N Genitourinary Y/N Endocrine (glands) Y/N

Cardiovascular Y/N Musculoskeletal Y/N Blood/lymph Y/N

Respiratory Y/N Integumentary (skin) Y/N Allergic/immunologic Y/N

Please explain \_\_\_\_\_

Diabetes? Y/N Type \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_ HIV? Y/N 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? \_\_\_\_\_

Name of family/primary care doctor \_\_\_\_\_ Date of last visit \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

## FAMILY/SOCIAL HISTORY

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, glaucoma, macular degeneration)?

Yes  No If yes, please explain: \_\_\_\_\_

Do you use tobacco products? \_\_\_\_\_ How much? \_\_\_\_\_ Do you drink alcohol? \_\_\_\_\_ How much? \_\_\_\_\_

## PERSONAL EYE INFORMATION

Reason for today's visit \_\_\_\_\_

Do you wear glasses? Y/N Do you wear contact lenses Y/N Do you have reading problems? Y/N

Are you currently experiencing any eye symptoms? Please check all that apply:

Eye Pain  Blurred Vision  Eyelid Crusting  Flashes of Light  Halos

Discharge  Light Sensitivity  Double Vision  Decreased Vision  Floaters

Have you ever had an eye injury? Please describe \_\_\_\_\_

Have you ever had eye surgery? Please list type, which eye, and approximate dates.

\_\_\_\_\_ R/L \_\_\_\_\_

\_\_\_\_\_ R/L \_\_\_\_\_

Have you ever been diagnosed with an eye disease? Please list condition, which eye, date diagnosed

\_\_\_\_\_ R/L \_\_\_\_\_ Currently being treated? Y/N

\_\_\_\_\_ R/L \_\_\_\_\_ Currently being treated? Y/N

Are you currently using any eye medications? Please list name and how often used: \_\_\_\_\_

Please check any of the following that you would like more information about:  Glaucoma  Cataract  Dry Eye

Macular Degeneration  Diabetic Eye Disease  Floaters & Flashes  Refractive Surgery  Contact Lenses

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Doctor's Initials Date