PATIENT HISTORY QUESTIONNAIRE

Please answer all questions.

Last Name ______________________ First Name ______________ Mi ____

Mr. Mrs. Ms. Miss. Rev. Dr.

Address ______________________ City ______________ Zip ________

Telephone (H) __________ (W) __________ SSN __________ Date of Birth ________

Employer ______________________ Occupation ______________

Emergency Contact/Telephone Number ______________________ Cell# ______________

Date of last eye exam __________ Dilated? __________ Today's Date __________

Payer of Services: ***(If different from above)***

Name ______________________ SSN ______________

Address ______________________ City ______________ Zip ________

Occupation ______________ Employed By ______________________

Work Phone #: (   ) __________

Medical Information

What is your general health? ______________________

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

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

Please explain ______________________

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? ________

Name of family doctor ______________________ Last visit ______________

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? ______________________

I agree to be personally and fully responsible for payment if my insurance denies payment.

______________________________ ______________

Signature Date

Doctor's Initials __________