PATIENT HISTORY QUESTIONNAIRE

Last Name: _____ First Name: _____ MI: _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ SSN: _____
Date of Birth: _____ Age: _____ Occupation: _____ Employer: _____
Emergency Contact Name: _____ Phone: _____
Date of last eye exam: _____ Dilated? Yes / No
Referred by _____

Medical Information

What is your general health? _____
Do you have problems with any of these systems? (Please circle yes or no.)

Gastrointestinal	Yes / No	Nervous	Yes / No	Endocrine (glands)	Yes / No
Ears/Nose/Throat	Yes / No	Urinary	Yes / No	Blood / Lymph	Yes / No
Cardiovascular	Yes / No	Muscle/Bones	Yes / No	Allergic / Immunity	Yes / No
Respiratory	Yes / No	Integumentary (skin)	Yes / No	Headaches	Yes / No
High blood pressure	Yes / No	Eyes	Yes / No	Mental	Yes / No

If yes, please explain _____
Diabetes Yes / No Type: _____ Date of Diagnosis: _____
Allergic to medication? Yes / No Which? _____ Reactions: _____
Other health problems _____
Current medication(s) _____ Check if none ___
Have you had any operations? Yes / No Kind? _____ When? _____
Name of family doctor _____
Date of last visit _____ Date of last tetanus shot _____

Family History

High blood pressure	Yes / No	Relationship _____	Macular degeneration	Yes / No	Relationship _____
Diabetes	Yes / No	Relationship _____	Retinal detachment	Yes / No	Relationship _____
Glaucoma	Yes / No	Relationship _____	Cataracts	Yes / No	Relationship _____

Personal Eye Information

Do you have any eye conditions or problems? Yes / No What Kind? _____
Have you had any eye operations? Yes / No Type _____ Date: _____
Have you had an eye injury? Yes / No Kind _____ Date: _____
Do you have glaucoma? Yes / No Cataracts? Yes / No Dry eyes? Yes / No
Do you have macular degeneration? Yes / No Retinal Detachment? Yes / No Blurred Vision? Yes / No
Do you wear glasses? Yes / No Contact Lenses? Yes / No Type? _____
Additional Information _____

Payment is expected at time of service.

How will payment be made? Cash ___ Check ___ Visa ___ MasterCard ___ Discover ___
Most insurance accepted. If under the age of 18, please have parent/guardian initial below:
I consent to the examination and treatment of my child _____
Patient Name _____ Guardian _____
Patient / Guardian Signature _____ Date _____