PATIENT HISTORY QUESTIONNAIRE

(must be updated at each visit)

Today's Date _____

Last name _____ First name _____ MI _____

Address _____ City _____ State _____ Zip _____

Marital Status ❑ Single ❑ Married ❑ Other Last Four Digits of SSN for Insured Person _____

Work Phone _____ Home Phone _____ Cell _____ Email _____

Date of birth _____ Occupation _____ Employer _____

Emergency Contact Name _____ Phone Number _____

Date of last eye exam _____ Dilated? Yes / No Referred by _____

Primary Vision Coverage _____ Secondary Coverage _____

Medical Insurance _____ Policy # _____ Group # _____

Insured Person: _____ D.O.B.: _____ Employer: _____

Medical Information

How is your general health? _____

Do you take medications for 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	Muscles/Bones	Yes / No	Allergic/Immunologic	Yes / No
Respiratory	Yes / No	Integumenary (skin)	Yes / No	Headaches	Yes / No
High Blood Pressure	Yes / No	Eyes	Yes / No	Mental	Yes / No

Please explain _____

Diabetes Yes / No _____ Type _____ Date of Diagnosis _____

Allergies to medication Yes / No Which? _____ Reactions? _____

Other health problems _____

Current medication(s) _____

Have you had any operations? Yes / No Kind? _____

Do you use Cigarettes / Tobacco? _____ Alcohol? _____

Name of family doctor and/or primary care physician _____

Date of last visit _____ Date your blood pressure was last checked _____

Family History

High Blood Pressure	Yes / No	Relation	_____	Macular degeneration	Yes / No	Relation	_____
Diabetes	Yes / No	Relation	_____	Retinal detachment	Yes / No	Relation	_____
Glaucoma	Yes / No	Relation	_____	Cataracts	Yes / No	Relation	_____

Personal Eye Information

Do you have any eye conditions or problems? Yes / No What kind? _____

Have you had any eye operations? Yes / No Kind _____ Date _____

Have you had an eye injury: Yes / No Kind _____ Date _____

Do you have glaucoma?	Yes / No	Cataracts?	Yes / No	Dry Eyes?	Yes / No
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 _____

Doctor Use Only

Reviewed by _____ ❍ No changes Date _____

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