Patient History Questionnaire

Exam Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Gender (circle): M F Title (circle): Mr. Mrs. Ms. Miss Dr. Rev. Preferred Name: _____

Address: _____ City_____ State: _____ Zip: _____

Social Security number_____-___-_____ Date of Birth: _____ Last Eye Exam: _____

Telephone (home): _____ (cell): _____ (work):_____

Email : _____

Emergency Contact / Phone #:_____

Name of family Doctor:_____

Employer: _____ Occupation: _____

How did you hear about our practice: Friend / Post Card / Mailing insert / Insurance / Web site / Drive by / Other

Medical Information

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

Allergy	Y / N	Ears/Nose/Throat	Y / N	Musculoskeletal	Y /N
Cardiovascular	Y / N	Blood / Lymphatic	Y / N	Neurological	Y / N
Endocrine	Y / N	Immunological/ Allergy	Y / N	Psychiatric	Y / N
Gastrointestinal	Y / N	Integumentary (Skin)	Y / N	Respiratory	Y / N

Please explain: _____

_____

Do you wear eye glasses ___Yes ____No Do you wear Contact Lenses ____Yes ____No

Are you interested in wearing contact lenses? ___ Yes ____ No Are you currently pregnant ____ Yes ____ No

Any other eye problems previously diagnosed? _____

Please indicate any major surgeries:_____

Please indicate any eye surgeries: _____ Year: _____

Please list all medications that you are taking. _____

_____

Are you allergic to any medications ___ Yes, ____ No If yes, please list them and your reaction _____

Please list any general allergies that you have _____

Ocular Family History		**Relationship to you**
Glaucoma	☐ Yes ☐ No	Who? _____
Cataracts	☐ Yes ☐ No	Who? _____
Macular Degeneration	☐ Yes ☐ No	Who? _____
Retinal Disease	☐ Yes ☐ No	Who? _____
Blindness	☐ Yes ☐ No	Who? _____
Lazy Eye	☐ Yes ☐ No	Who? _____
Other Eye Disease	☐ Yes ☐ No	Who? _____
Systemic Family History		
Hypertension	☐ Yes ☐ No	Who? _____
Diabetes	☐ Yes ☐ No	Who? _____
Heart Disease	☐ Yes ☐ No	Who? _____
Cancer	☐ Yes ☐ No	Who? _____

Circle one of the following: Never smoked, Former Smoker, Current Smoker

How often do you drink alcohol: ___None, _____ social use, _____1-2 drinks per day, ___more than 2 per day.

How often do you use narcotics: ____Never, _____ recreational use, ____ chemically dependent