PATIENT HISTORY QUESTIONNAIRE

Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ ZIP _____
Telephone (W) _____ (H) _____ (Cell) _____
SSN _____-_____-_____ Date of Birth _____
Occupation _____ Employer _____
Medical Insurance _____ Vision Insurance _____
Name of parent presenting with child (if minor) _____
Consent given to treat child? Y/N *signature of parent:* _____
Emergency Contact Telephone Number _____
e-mail address (Internal use only) _____
Today's date _____ Date of last eye exam _____ Dilated? _____

Medical Information

What is your general health? _____
Do you have any problems with any of these systems? *(Please circle all that apply)*

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	Dermatologic	Y/N	Immunologic	Y/N

Please explain _____

Please answer all that apply:
Diabetes Y/N Type _____ Date of diagnosis _____
Allergies Y/N Allergic to what? _____ What happens? _____
Medication allergy Y/N What happens? _____
Other health problems _____
Current medication(s) _____
Have you had any operations? Y/N What kind? _____ When? _____
Name of family doctor _____ Date of 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? _____

Personal Eye History

Have you ever 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 _____
Whom may we thank for referring you? _____
Doctor's initials _____

Information Release

Please list name(s) of anyone to whom you would like information released:

Name _____ Phone # _____

Name _____ Phone # _____

Name _____ Phone # _____

Patient Signature _____ Date _____