PATIENT HISTORY QUESTIONNAIRE

Today's Date: _____

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name _____ First Name _____ MI _____
Date of birth _____
Date of Last Eye Exam_____ Dilated? Yes / No Date of Last Physical Exam_____

If patient is a minor, your name_____

Personal Medical Information

What is your general health? _____
Are you pregnant or lactating? _____
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	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (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 probems _____
Current medication(s) _____
Have you had any operations? Yes/No Kind? _____When? _____
Name of family doctor _____Phone_____

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 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
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 _____

Reviewed by _____ O No Changes O Changes noted & initialed Date _____
Reviewed by _____ O No Changes O Changes noted & initialed Date _____