PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: THIS QUESTIONAIRE IS TO BE REVIEWED AT EACH APPOINTMENT. PLEASE ANSWER ALL QUESTIONS

DATE: PATIENT EMAIL:

Last Name_____ **First Name**_____ **MI**___ **Marital Status S M D WID**

Address_____ **City**_____ **State**___ **Zip**_____

Home Phone_____ **Work Phone**_____ **Cell Phone**_____

Date of Birth_____ **Occupation**_____ **Employer**_____

Date of Last Exam(*If not done at this office*)_____ **Exam done by Dr.**_____

SIGNATURE_____ **DATE**_____

Primary INS Holder Last 4 Digits of SS#_____ **Patient's SS#**_____

Medical Information-Review of systems

What is your general health? Excellent ☐ Good ☐ Fair ☐ Poor☐

Do you have problems with any of the following?

Cardiovascular..... ☐ Yes ☐ No Respiratory.....☐ Yes ☐ No
High Blood Pressre.....☐ Yes ☐ No
Eyes (Burn / Itch)..... ☐ Yes ☐ No Do You Smoke.....☐ Yes ☐ No
Endocrine (glands)..... ☐ Yes ☐ No
Allergic/Immunologic.....☐ Yes ☐ No
Diabetes ☐ Yes ☐ No Type_____ Date of Diagnosis_____

CURRENT MEDICATIONS_____

_____

Allergies to Medications: ☐ Yes ☐ No Which?_____
Reaction(s)?_____
Other Health Problems_____
NAME and **CITY** of Family Doctor_____

PERSONAL EYE INFORMATION

Have you had any eye operations? ☐ Yes ☐ No Type_____ Date_____
Have you had an eye injury? ☐ Yes ☐ No Kind_____ Date_____
Retinal Detachments? ☐ Yes ☐ No Blurred Vision? ☐ Yes ☐ No
Macular Degeneration ☐ Yes ☐ No Glaucoma? ☐ Yes ☐ No Cataracts? ☐ Yes ☐ No
Do you wear Glasses? ☐ Yes ☐ No Contact Lenses? ☐ Yes ☐ No Brand_____
Additional Information_____
Who may we thank for referring you to our office?_____

Family Eye History

Glaucoma? ☐ Yes ☐ No Cataracts? ☐ Yes ☐ No
Retinal Disease? ☐ Yes ☐ No Macular Degeneration? ☐ Yes ☐ No
Blindness? ☐ Yes ☐ No Lazy Eye? ☐ Yes ☐ No
Diabetes? ☐ Yes ☐ No Cancer? ☐ Yes ☐ No Are you colorblind? Yes or No