

# PATIENT HISTORY QUESTIONNAIRE

(must be updated at each visit)

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (W) \_\_\_\_\_ (H) \_\_\_\_\_ Marital Status  Single  Married  Other  
SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_ Insured Employee \_\_\_\_\_ Insured Employer \_\_\_\_\_  
Medical Insurance company \_\_\_\_\_ Group # \_\_\_\_\_ Insured SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Parent or responsible party \_\_\_\_\_ Do you participate in a flex spending account Y / N  
How will you settle your account today?  Check  Cash  Credit Card  
Date of last eye exam \_\_\_\_\_ Dilated? \_\_\_\_\_ Today's date \_\_\_\_\_

## MEDICAL INFORMATION

What is your general health? \_\_\_\_\_  
Do you have problems with any of these systems? (please circle all that apply)

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genintourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine (glands)	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Blood/lymph	Y/N
				Allergic/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? \_\_\_\_\_ Headaches Y/N  
Other health problems \_\_\_\_\_  
Current medication(s) \_\_\_\_\_  
Have you had any operations? Y/N Kind? \_\_\_\_\_ When? \_\_\_\_\_  
Do you use cigarettes/tobacco? \_\_\_\_\_ Alcohol? \_\_\_\_\_ Other substance(s)? \_\_\_\_\_  
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? \_\_\_\_\_ Relation \_\_\_\_\_

## PERSONAL EYE INFORMATION

Have you 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 \_\_\_\_\_  
Additional information \_\_\_\_\_  
Whom may we thank referring you? \_\_\_\_\_  
Doctor's initials \_\_\_\_\_

# QUESTIONNAIRE