PATIENT HISTORY QUESTIONNAIRE

Today's Date:___________________________ Date of Birth:__________________ Gender: M/F___________

Last name:_____________________________ First name:______________________________ MI:___________

Address:_______________________________ City:________________________ State:__________Zip:________

Telephone:_______________________________(home)______________________________________(work/cell)

Occupation:__________________________________ Employer:____

Emergency Contact:___________________________ Relationship:________________ Phone#:_____________

How did you find us? *Doctor referral* *Friend/family* *Internet search* *Other* ____________________

Whom may we thank for referring you? ____

MEDICAL HISTORY

How is your general health?____________________________________

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

Cardiovascular	Y/N	Nervous	Y/N	Eyes	Y/N
Ear/Nose/Throat	Y/N	Genitourinary	Y/N	Psychiatric	Y/N
Gastrointestinal	Y/N	Musculoskeletal	Y/N	Endocrine	Y/N
Respiratory	Y/N	Skin	Y/N	Blood/lymphatic	Y/N

Please describe:____

Do you have a history of any of the following?

Diabetes	Y/N	Cancer	Y/N	Asthma/allergies	Y/N
High blood pressure	Y/N	Autoimmune dis.	Y/N	Hepatitis	Y/N
High cholesterol	Y/N	Arthritis	Y/N	HIV/AIDS	Y/N
Stroke	Y/N	Migraines	Y/N	Seasonal allergies	Y/N
Heart attack	Y/N	Thyroid disease	Y/N		

Please list current medications:____

____

List any allergies to medications:____

Name of Primary Care Physician:_______________________________Specialist:____________________________

When was your last physical?__________________________Does your doctor want a report of this exam? Y/N

Have you had any operations? Y/N____

How often do you use tobacco/cigarettes?_____________ Alcohol?__________Other substances?____________

FAMILY HISTORY

History of:	Y/N	Relationship	History of:	Y/N	Relationship
High blood pressure			Macular degeneration		
Diabetes			Glaucoma		
Stroke			Retinal detachment		
Heart attack			Keratoconus		

OCULAR HISTORY

Date of your last eye exam:__________________Where?_____________________Were your eyes dilated? Y/N

Have you had any eye injuries? Y/N____

Have you had any eye surgeries? Y/N____

Do you have a history of any of the following?

Cataracts	Y/N	Dry eyes	Y/N	Headaches/Migraines	Y/N
Glaucoma	Y/N	Flashes/Floaters	Y/N	Computer related discomfort	Y/N
Macular degeneration	Y/N	Crossed Eyes	Y/N	Itchy eyes from allergies	Y/N
Retinal detachment	Y/N	"Lazy Eye"	Y/N	Light sensitivity	Y/N

Do you wear glasses? Y/N Type: Distance Near Bifocal Progressive

Do you wear contact lenses? Y/N Type/Brand:____

How many hours/day do you wear them?______________ Preferred Cleaning Solution:____________________

How often do you replace them?______________________Are they comfortable?___________________________

Are there any other issues to address today?____

Reviewed by Doctor: _____________