Patient History Questionnaire

Last Name: ____________________ First Name: _________________ MI: __________

Date of Birth: ____________ Todays Date: _____________

Medical Information

What is your general health? ____

Do you have any problems with any of these systems?

Gastrpointestinal	Y/N	Muscle/Bone	Y/N
Nervous	Y/N	Headaches	Y/N
Blood/Lymph	Y/N	Respiratory	Y/N
Ears/Nose/Throat	Y/N	Integumentary (Skin)	Y/N
Urinary	Y/N	Mental	Y/N
Allergic/Immunologic	Y/N	High Blood Pressure	Y/N
Cardiovascular	Y/N	Eyes	Y/N

Other: ____

Diabetes: Y/N Type: _________________ Date of Diagnosis: ___________

Allergies to medication? Y/N
Which? ____

Other Allergies? Y/N
Which? ____

Current Medications: ____
____

Have you had any operations? ____
____

Do you smoke? Y/N
Drink alcohol? Y/N
History of drug abuse? Y/N

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 ____________

Personal Eye History

Do you have any eye conditions or problems? Y/N What Kind? _______________

Have you had any eye operations or injuries? Y/N What Kind? ____________________

Do you wear glasses? Y/N
Contacts Lenses? Y/N What Kind? _________________

How did you hear about our office? _____________________________

Doctors Use Only:

Reviewed _______________ Date ____________

Reviewed _______________ Date ____________

Reviewed_______________ Date____________