Today's Date: _______________

PATIENT HISTORY QUESTIONNAIRE

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

□ New patient □ Returning Patient □ Male □ Female □ Mr. □ Mrs. □ Ms. □ Miss. □ Dr.

Last Name ______________________________First Name________________________MI________

Address _________________________________ City ______________ State ________ Zip _______

Home Phone _________________Work Phone __________________Cell Phone________________

Email______________________Emergency Contact Name ___________________#_____________

Date of Birth ____________ Occupation_____________________ Employer ____________________

Referred By: □ Yellow Pages □ Internet □ Walk in □ Friend or Relative- Name___________________

Date of Last Eye Exam_______________ Dilated? Yes / No

Primary Vision Coverage _____________________________ ID# _______________________

If Patient is a Minor, Name of Parent or Guardian____

Purpose of Today's Visit: □ Routine Exam □ Glasses □Contacts □ Laser Vision Correction □ Other

Medical Information

How is your general health? ____

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
High Cholesterol	Yes/No	Currently Pregnant	Yes/No		

Please explain ____

Diabetes Yes/No Type ____________________________ Date of diagnosis_____________________

Allergies to Medication Yes/No Which? _________________ Reactions? __________________________

Other health problems____

Current medication(s) ____

Name of family doctor______________________________________ Date of last visit________________

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 _________________________

Computer user? Yes/No Hours Per Day___________

Additional information ____

Thank You for Choosing Dr. Scheffel's Eye Care Center