PATIENT HISTORY QUESTIONNAIRE
(Must be updated at each visit)

Today's date_____________
Last Name________________________________ First Name__________________________ MI_____
Date of birth____________________

Medical Information

Do you have problems with any of these systems?

Eyes Y / N	Gastrointestinal Y / N	Nervous Y / N	Mental Y / N
Ears/Nose Throat Y / N	Genitourinary Y / N	Endocrine (glands) Y / N	
Cardiovascular Y / N	Musculoskeletal Y / N	Blood/lymph Y / N	
Respiratory Y / N	Integumentary (skin) Y / N	Allergic/immunological Y / N	

Please explain____
____

Please answer all that apply:
Diabetes Y / N Type__________ Approximate date of diagnosis
Allergies Y / N Allergic to what?__________________________ What happens?_________________
Medication allergies Y / N Allergic to what medications?____________________________________
Headaches Y / N
Other health problems____
List current medications: ____
____
Do you use cigarettes/tobacco? Y / N Alcohol? Y / N Other substance?___________________
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 Y / N What kind? ________________________________Relation________________

Personal Eye Information

Have you had any eye operations? Y / N Type_________________________ Date________________
Have you had any 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 Describe____
Do you wear eyeglasses? Y / N Contact lenses? Y / N Type___________________________________

If there are no changes in your history or meds **since your last eye exam** then initial and date
(Initial and date only 1 place below with each office visit):

1. Initials_______ Date_________
2. Initials_______ Date_________
3. Initials______ Date________
4. Initials______ Date________