

PATIENT HISTORY QUESTIONNAIRE

FOR OFFICE USE ONLY

2005 2006 2007 2008

TODAY'S DATE _____

DR. MR. MRS. MS.

Last Name

First Name

Middle Initial

ADDRESS _____

Street Address

City

State

Zip Code

AGE _____ BIRTHDATE ____/____/____ SOCIAL SECURITY # ____/____/____

PHONE (H) _____ (W) _____ CELL _____

OCCUPATION _____ EMPLOYER _____

E-MAIL _____ SPOUSE OR RESPONSIBLE PARTY _____

MAJOR MEDICAL INSURANCE _____ VISION INSURANCE _____

PRIMARY CARE DOCTOR/PHONE # _____

EMERGENCY CONTACT/PHONE # _____

I, THE UNDERSIGNED, UNDERSTAND THAT ALL CHARGES NOT COVERED BY MY INSURANCE ARE MY RESPONSIBILITY AND I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS TO MY INSURANCE COMPANY.

PATIENT'S SIGNATURE

MEDICAL INFORMATION

How would you describe your general health? _____

Do you have problems with any of these systems? (PLEASE CIRCLE ALL THAT APPLY)

Gastrointestinal	Nervous	Mental	Eyes
Ears/Nose/Throat	Genitourinary	Endocrine (glands)	Respiratory
Cardiovascular	Musculoskeletal	Blood/lymph	Skin
			Allergic/immunologic

Please explain _____

Do you have any of the following conditions?

Diabetes Y/N Type _____ Date of diagnosis _____ High blood pressure Y/N Arthritis Y/N

Headaches Y/N How often? _____ Migraines Y/N How often? _____

Other health problems _____

List all Medications/Vitamins/Herbs _____

List any allergies (including medications) _____

Have you had any operations? Y/N Kind? _____ When? _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substance(s)? _____

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 *NOTE ONLY NEW PATIENTS NEED TO FILL OUT*****

Date of last eye exam _____ Have your eyes ever been dilated? Y/N Have you had any eye operations? Y/N

List type of eye operations _____ 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 _____

Do you want new glasses today? Y/N How old are your glasses/contact lenses? _____ Do your glasses have prism? Y/N

Do you drive? Y/N Additional information _____

If you are a new patient, whom may we thank for referring you? _____

Doctor's initials _____ Date Updated _____