# PATIENT HISTORY QUESTIONAIRE

Print Name _____ Age_____ Date_____
Last First MI

Address_____ City_____ State_____ Zip Code_____
Phone (Hm) _____ (W) _____ (Cell) _____ (Emergency #)_____
Gender ☐M ☐F Birthdate_____ Soc. Sec. No._____-_____-_____ Driver Lic.#_____
If Married (Spouse name)_____ Children (Names/age) _____
Occupation _____ Employer _____ Medical Insurance _____
Vision Insurance _____ Member name _____ I.D.# _____

Are you interested in **CONTACT LENSES? ____CRT? ____ LASER SURGERY? ____ COMPUTER GLASSES? ____ SPORT GLASSES? _____**

## MEDICAL INFORMATION

**How is your general Health? _____**

**Do you have any problems with any of the following systems?**

| | | | | | |
|---|---|---|---|---|---|
| Eyes | Y / N | Gastrointestinal | Y / N | Neurological | Y / N |
| Ears, Nose, Throat | Y / N | Genitourinary | Y / N | Endocrine | Y / N |
| Cardiovascular | Y / N | Musculoskeletal | Y / N | Blood/Lymphatic | Y / N |
| Respiratory | Y / N | Integumentary (skin) | Y / N | Allergic/Immunologic | Y / N |
| Psychiatric | Y / N | Please Explain _____ | | | |

**Do you have any of the following conditions?**

| | | | | | |
|---|---|---|---|---|---|
| Glaucoma | Y / N | Macular degeneration | Y / N | Blurred vision | Y / N |
| Cataracts | Y / N | Dry eyes | Y / N | | |
| Do you wear glasses | Y / N | Do you wear contacts | Y / N | | |
| Diabetes | Y / N | Type_____ | | When Diagnosed?_____ | |
| Allergies | Y / N | Allergic to what?_____ | | What happens with allergy? _____ | |
| Med. Allergy | Y / N | What medications? _____ | | What happens? _____ | |
| Headaches | Y / N | mild/moderate/severe | When do you get them?_____ | Where does it hurt?_____ | |

| | | | |
|---|---|---|---|
| Have you had any eye operations | Y / N | Type _____ | Date _____ |
| Have you had any eye injury | Y / N | Type _____ | Date _____ |
| Have you had any medical operations | Y / N | Type _____ | Date _____ |

Current Medications?_____

**Do you use any of the following?**

| | | | | |
|---|---|---|---|---|
| Cigarettes/tobacco | Y / N | Alcohol | Y / N | |
| Other drugs/substances | Y / N | Herbal Supp./OTC | Y / N | What kind?_____ |

Name of Family Doctor _____ City _____ Date of last visit _____
Date of last tetanus shot _____ Do you have an Advance Directive for health care?_____
Date of last eye exam _____ Dilated Y / N Date of last prescription _____
Any additional Information_____

## 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 conditions | Y / N | What kind? _____ | | | Relation _____ |

**Whom may we thank for referring you?_____**

**I, hereby, authorize services, release of information and or referrals deemed necessary for the welfare of my vision.**

**Signed** _____ **Date** _____

Additional Dates:

**P.S. We accept referrals for your family and friends. New patients welcome!**