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!