PATIENT HISTORY QUESTIONNAIRE

Mr. Miss Ms. Mrs. Dr. Race: African Amer.[ ] Asian [ ] Hispanic [ ] White [ ] Other _____

Last name _____ First name _____ MI ____ Date _____

Address _____City_____Zip_____ Date of birth _____

Telephone (H)_____ (W) _____ (Cell) _____

Occupation _____ Employer _____ Soc. Sec. No. _____-____-_____

E-mail _____Emergency contact_____Telephone_____

Vision Insurance _____ Medical Insurance & Card number _____

Primary Care Doctor _____ Preferred Communication: Phone ___ or E-mail ___

Whom may we thank for referring you to our office? _____

Personal Eye History

Have *you* had any eye injuries or surgeries? Y / N Type _____ Date_____

Other eye problems? Y / N _____ Eye Medications Y / N _____

Review of Systems

Do *you* have problems with any of the following? [ ] No medical problems

Gastrointestinal	Y / N _____	Thyroid	Y / N_____	Allergic/Immunologic	Y / N_____
Ears/Nose/Throat	Y / N _____	Cancer	Y / N _____	Musculoskeletal (Arthritis)	Y / N_____
Cardiovascular	Y / N _____	Respiratory	Y / N _____	Nervous System	Y / N _____
Blood/lymph	Y / N _____	Mental	Y / N_____	Other	Y / N _____
Pregnant?	Y / N How Long____	Nursing?	Y / N_____	_____	

Diabetes? Y / N If Yes: How Long?_____ Most recent blood glucose or A1C_____

Allergic to medication? Y / N _____

Have you had any surgeries? Y / N For _____ When?_____

Do you use: Alcohol _____drinks/week Narcotics Y / N Tobacco? Y / N Packs/Day ____ Quit_____ years ago

Are you currently taking medication? Y / N [ ] See attached list

Medication Name	Reason for taking	Dosage / How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Does anyone in *your* ***immediate family*** have a history of any of the following? (Please indicate Maternal or Paternal)

High blood pressure Y / N Relation_____ Diabetes Y / N Relation_____ Glaucoma Y / N Relation _____
Retinal detachment Y / N Relation_____ Cataracts Y / N Relation _____
Macular Degeneration Y / N Relation _____ Other eye condition Y / N _____ Relation _____

Updated ____/_____/_____Patient's Initials _____	Doctor's initials _____ Date _____
Updated ____/_____/_____Patient's Initials_____	Doctor's initials _____ Date _____
Updated ____/_____/_____Patient's Initials_____	Doctor's initials _____ Date_____
Updated ____/_____/_____Patient's Initials_____	Doctor's initials _____ Date_____