

**PATIENT HISTORY QUESTIONNAIRE**

**DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_

Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Emergency \_\_\_\_\_

Sex M F Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Married Single Other \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Last Medical Exam \_\_\_\_\_

Previous Eye Doctor \_\_\_\_\_ Last Eye Exam \_\_\_\_\_

Referred by \_\_\_\_\_ Payment Plan \_\_\_\_\_

Major Medical Insurance \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Responsible Party (If same as above check here and go to next section. \_\_\_\_\_)

Name \_\_\_\_\_ SSN \_\_\_\_/\_\_\_\_/\_\_\_\_. Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Spouse's Name (if married) \_\_\_\_\_

**MEDICAL INFORMATION**

Do you have any **allergies to medications**? Yes \_\_\_\_ No \_\_\_\_ If yes list \_\_\_\_\_

Other allergies? Yes \_\_\_\_ No \_\_\_\_ If yes list. \_\_\_\_\_

List any **medications you are currently taking and the reason you take them if known.** (include oral contraceptives, aspirin, over the counter meds, and home remedies.)

List all major surgeries, injuries, and/or hospitalizations you have had. (give approximate dates) \_\_\_\_\_

Are you pregnant or nursing? Yes \_\_\_\_ No \_\_\_\_

**PERSONAL EYE HISTORY**

Have you had any **eye surgery**? Yes \_\_\_\_ No \_\_\_\_ If yes explain \_\_\_\_\_

Have you had any **eye injuries**? Yes \_\_\_\_ No \_\_\_\_ If yes explain \_\_\_\_\_

Do you have **glaucoma**? Yes \_\_\_\_ No \_\_\_\_ **Cataracts**? Yes \_\_\_\_ No \_\_\_\_ **Macular degeneration** Yes \_\_\_\_ No \_\_\_\_

Do you wear glasses? Yes \_\_\_\_ No \_\_\_\_ If yes, how old are your current lenses? \_\_\_\_\_

Do you wear contact lenses? Yes \_\_\_\_ No \_\_\_\_ If yes, how old are your current lenses? \_\_\_\_\_

If you wear contact lenses: Type Soft / Rigid / Disposable / Extended Wear / Bifocal / Tinted

If your contact lenses are disposable, how often do you replace them? \_\_\_\_\_

**FAMILY HISTORY ( Include parents, children, siblings, grandparents – living or deceased)**

CONDITION	RELATIONSHIP TO YOU	CONDITION	RELATIONSHIP TO YOU
Blindness	Yes No _____	Macular Degeneration	Yes No _____
Cataract	Yes No _____	Retinal Detachment	Yes No _____
Crossed eyes	Yes No _____	Cancer	Yes No _____
Glaucoma	Yes No _____	Diabetes	Yes No _____

**OVER**

