

## PATIENT HISTORY QUESTIONNAIRE

**Mr/Mrs/Miss/Ms/Dr. (please circle one)**

Last Name \_\_\_\_\_ M/F \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Date of birth \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Date of Last Eye Exam \_\_\_\_\_ Dilated? Yes / No Referred By: \_\_\_\_\_

**Account responsible-**

**Name** \_\_\_\_\_ **Address**(if different) \_\_\_\_\_  
**Primary Vision Coverage** \_\_\_\_\_ **ID#** \_\_\_\_\_

**Medical Information**

What is your general health? \_\_\_\_\_  
Do you have problems with any of these systems? (Please circle yes or no.)  
Gastrointestinal Yes/No Nervous Yes/No Endocrine(glands) Yes/No  
Ears/Nose/Throat Yes/No Urinary Yes/No Blood/Lymph Yes/No  
Cardiovascular Yes/No Muscles/Bones Yes/No Allergic/Immunologic Yes/No  
Respiratory Yes/No Headaches Yes/No High Blood Pressure Yes/No  
Eyes Yes/No  
Diabetes Yes/No Type \_\_\_\_\_ Date of diagnosis \_\_\_\_\_  
Allergies to Medication Yes/No Which? \_\_\_\_\_ Reactions? \_\_\_\_\_  
Other health problems \_\_\_\_\_  
Current medication(s) \_\_\_\_\_  
Have you had any operations? Yes/No Kind? \_\_\_\_\_ When? \_\_\_\_\_  
Name of family doctor \_\_\_\_\_  
Date of last visit \_\_\_\_\_ Date of last tetanus shot \_\_\_\_\_

**Family History**

High blood pressure Yes/No Relation \_\_\_\_\_ Macular degeneration Yes/No Relation \_\_\_\_\_  
Diabetes Yes/No Relation \_\_\_\_\_ Retinal detachment Yes/No Relation \_\_\_\_\_  
Glaucoma Yes/No Relation \_\_\_\_\_ Cataracts Yes/No Relation \_\_\_\_\_

**Personal Eye Information**

Do you have any eye conditions or problems? Yes/No What kind? \_\_\_\_\_  
Have you had any eye operations? Yes/No Type \_\_\_\_\_ Date \_\_\_\_\_  
Have you had an eye injury? Yes/No Kind \_\_\_\_\_ Date \_\_\_\_\_  
Do you have glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No  
Macular degeneration? Yes/No Retinal detachment? Yes/No Blurred vision? Yes/No  
Do you wear glasses? Yes/No Contact lenses? Yes/No Type \_\_\_\_\_  
Any other Additional information \_\_\_\_\_

I understand that I am responsible to pay for all services rendered by this office. I also understand that in the event my insurance does not pay for the billed services, I will be responsible for the payment of said services in a prompt manner.

X \_\_\_\_\_  
Signature (Parent signature if minor)

\_\_\_\_\_  
Date