Patient History Questionnaire

IMPORTANT: This questionnaire will be reviewed at future exams. Please answer all questions.
Answers to these questions are kept confidential according to federal HIPAA regulations.

Last Name_____ First Name_____ MI___ Today's Date_____

DOB_____ Occupation_____ Employer_____

Phone: (H)_____ (W)_____ Third Party/Insurance Carrier _____

Personal Eye Information

Date of Last Eye Exam (est.): _____

Do you wear glasses now? Y / N
If not, have you ever? Y / N
If so, are they satisfactory? Y / N

Do you wear contact lenses now? Y / N
If not, have you ever? Y / N
Are you presently interested in contacts? Y / N

Do you have, or have you ever had, unusual eye/visual symptoms, such as:

Double vision? Y / N
Seeing light flashes? Y / N
Loss of vision in one or both eyes? Y / N
Considerable eye discomfort? Y / N
Other unusual symptoms? Y / N

Have you ever had any medical attention to your eyes (e.g. injuries, surgery, eye patched) ? Y / N
If so, please describe _____

What is your main reason for today's visit?_____
If you're new to our office, how did you hear about us? _____

Medical Information

How would you rate your general health? Very Good - Good - Fair – Poor

Do you have problems with any of these systems? **(Please circle Y or N.)**

Gastrointestinal:	Y / N	Nervous:	Y / N	Diabetes:	Y / N	Allergies:	Y / N
Ears/Nose/Throat:	Y / N	Skin:	Y / N	Blood/Lymph:	Y / N	Headaches:	Y / N
Cardiovascular:	Y / N	Endocrine:	Y / N	Muscles/Bones:	Y / N	Allergies to Meds:	Y / N
Respiratory:	Y / N	Urinary:	Y / N	Hypertension:	Y / N	If yes, which:	_____

Details of positive responses:

Name of Primary Care Physician: _____ Last visit (est.): _____

Are you taking medications currently? Y / N If so, please list: _____
_____

Have you had any operations/surgery? Y / N If so, describe: _____

Family and Social History

Is there a family history of any of the following:

Glaucoma	Y / N	Retinal Detachment	Y / N	Stroke	Y / N	Diabetes	Y / N
"Lazy Eye"	Y / N	Macular Degeneration	Y / N	Heart Disease	Y / N		

Any other significant personal or family history? Y / N _____
Are you, or have you been, a smoker? Y / N