# Patient History Questionnaire

**Patient Name: Last** _____ **First** _____ **MI** ____
**Parents name*(if minor)*** _____ **Male** _____ **Female** ____
**Address** _____ **City** _____ **State** _____ **Zip** _____
**Telephone Home** _____ **Work** _____ **Cell** _____
**SSN** _____ **DOB** _____ **Today's date** _____ **Age** ____
**Email address** _____
**Occupation** _____ **Employer** _____
**Spouse** _____ **Children (names)** _____
**Have we seen anyone from your family before? ☐ Y ☐ N Whom?** _____
**Emergency Phone number** _____
**Date of last eye exam?** _____ **Dilated? ☐ Y ☐ N**

## PERSONAL EYE INFORMATION

**Have you had any eye operations? ☐ Y ☐ N Type** _____ **Date** _____
**Have you had an eye injury? ☐ Y ☐ N Kind** _____ **Date** _____
**Do you have Glaucoma? ☐ Y ☐ N Cataract? ☐ Y ☐ N Blurred vision? ☐ Y ☐ N**
**Other eye problems? Describe** _____
**Do you wear glasses? ☐ Y ☐ N Contact lenses? ☐ Y ☐ N Type?** _____
**Additional information** _____
**Do you use a computer at work/home? ☐ Y ☐ N Hours per day?** _____
**Interested in: Laser Vision Correction? ☐ Y ☐ N Contact Lenses? ☐ Y ☐ N Glasses? ☐ Y ☐ N**

## FAMILY HISTORY

**High blood pressure Y/N Relation** _____ **Diabetes Y/N Relation** _____
**Macular degeneration Y/N Relation** _____ **Glaucoma Y/N Relation** _____
**Retinal detachment Y/N Relation** _____ **Cataracts Y/N Relation** _____
**Other eye conditions Y/N Type** _____ **Relation** _____

## MEDICAL INFORMATION

**Do you have problems with any of these systems?**

| | | | | | |
|---|---|---|---|---|---|
| **Cardiovascular** | **☐ Y ☐ N** | **Blood Pressure** | **☐ Y ☐ N** | **Respiratory** | **☐ Y ☐ N** |
| **Blood/Lymph** | **☐ Y ☐ N** | **Gastrointestinal** | **☐ Y ☐ N** | **Endocrine** | **☐ Y ☐ N** |
| **Ear/Nose/Throat** | **☐ Y ☐ N** | **Musculoskeletal** | **☐ Y ☐ N** | **Nervous** | **☐ Y ☐ N** |
| **Allergic/Immunologic** | **☐ Y ☐ N** | **Alcohol** | **☐ Y ☐ N** | **Tobacco** | **☐ Y ☐ N** |
| **Drugs** | **☐ Y ☐ N** | | | | |

**Please explain** _____
**Diabetes ☐ Y ☐ N Type** _____ **Date of diagnosis** _____
**Allergies ☐ Y ☐ N Allergic to what** _____
**Medical Allergies ☐ Y ☐ N** _____ **Headaches ☐ Y ☐ N** _____
**Other health problems:** _____
**Current medications:** _____

**Name of family doctor:** _____ **Phone #** _____
**Insurance company:** _____ **Policy #** _____
**Primary Insured Name:** _____
**Primary DOB:** _____ **Last 4 Digits of SS:** _____
**Responsible Party:** _____
**Review Date** _____ / _____ / _____ / _____