## **Patient History Questionnaire**

Patient Name: Last		First			MI	
Parents name(if minor)			Mal	e Fe	male	
Address		City	Stat	e Zij	p	
Telephone Home		Work		Cell		
SSN	DO	OB	Today's dat	<u>e</u>	Age	
Email address			v	-	_	
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						
Dute of last cyc exam.						
DEDGONAL EVE INCODICATION						
PERSONAL EYE INFORMATION						
Have you had any eye operations? $\square Y \square N$ Type Date						
Have you had an eye injury? □ Y □ N Kind Date						
Do you have Glaucoma? $\Box$ Y $\Box$ 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 HISTOR	RY			
High blood pressure Y/N Relation Diabetes Y/N Relation						
Macular degeneration Y	Glaucoma Y/N Relation					
Retinal detachment Y/N Relation		Cataracts Y/N Relation				
	Relation					
Other eye conditions Y	/N Type		Kelation _			
MEDICAL INFORMATION						
MEDICAL INFORMATION						
Do you have problems v						
Cardiovascular		<b>Blood Pressure</b>		Respiratory		
Blood/Lymph		Gastrointestinal		Endocrine		
Ear/Nose/Throat		Musculoskeletal		Nervous		
Allergic/Immunologic		Alcohol		Tobacco	$\square Y \square N$	
Drugs						
Please explain						
Diabetes □ Y □ N Type						
Allergies □ Y □ N Allergic to what						
Medical Allergies □ Y □ N Headaches □ Y □ N						
Other health problems:						
<b>Current medications:</b>	'					
current incurcutions.						
Name of family doctor:	Phone #					
Insurance company:	Policy #					
Primary Insured Names			1 0110	J "		
Primary Insured Name: Primary DOB:						
Responsible Party:		,			,	
Review Date		/	/		/	