PATIENT HISTORY QUESTIONNAIRE

(Required by Insurance Carriers and must be updated at each visit)

Patient's Last Name ______________________ First Name ______________________ MI ______

If Child, Parent's Name ______________________ If Married, Spouse's Name ______________________

Address ______________________ City ______________ Zip Code ____________ Apt# ______

Telephone (Home) ______________________ (Work) ______________ Date of Birth ______________

Emergency Telephone Number ______________________ None Available (circle)

Occupation ______________________ Employer ______________________

Social Sec. No. ______________________ Name of Vision Insurance Plan ______________________

Date of Last Eye Exam ______________________ Dilated? ____________ Today's Date ______________

Medical Information

What is your general health? ____

Do you have problems with any of these systems? (*Please circle all that apply*)

Eyes Y/N	Gastrointestinal Y/N	Nervous Y/N	Mental Y/N
Ears/Nose/Throat Y/N	Genitourinary Y/N	Endocrine Y/N	
Cardiovascular Y/N	Musculoskeletal Y/N	Blood/Lymph Y/N	
Respiratory Y/N	Integumentary (skin) Y/N	Allergic/Immunologic Y/N	

Please explain ____

Please answer all that apply:

- Diabetes Y/N Type ______________________ Date of diagnosis ______________________

Allergies Y/N Allergic to what? ______________________ What happens? ______________________

- Medication allergy Y/N What happens? ____

Other health problems ____

- Current Medication(s) ____

Have you had any operations? Y/N Type: ______________________ When? ______________

Do you use cigarettes/tobacco? Y/N __________ Alcohol? Y/N __________ Other substance(s)? Y/N __________

Name of family doctor ______________________ Date of last visit ______________________

Family History

High Blood Pressure Y/N Relation ______________________ Macular degeneration Y/N Relation ______________________

Diabetes Y/N Relation ______________________ Retinal detachment Y/N Relation ______________________

Glaucoma Y/N Relation ______________________ Cataracts Y/N Relation ______________________

Other eye conditions Y/N What kind? ______________________ Relation ______________________

Personal Eye Information

Have you had any eye operations? Y/N Type ______________________ Date ______________

Have you had any eye injury? Y/N Kind ______________________ Date ______________

Do you have glaucoma? Y/N Cataracts? Y/N Dry Eyes: Y/N Blurred Vision? Y/N

Other eye problems? Y/N What kind? ____

Do you wear glasses? Y/N Contact Lenses? Y/N Type ______________________________

Additional information ____

Patient, Parent or Guardian's Signature ______________________________ Doctors initials __________

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