Today's Date_____

Patient History Questionnaire

Name_____ DOB_____ Age_____

Address_____ City_____ State_____Zip_____

Phone (Cell)_____ (Home) _____

Email_____ Referred by _____

For insurance requirements what is your gender __M or __F Preferred pronoun (optional) ☐he ☐she ☐they

Medical Information

Describe your general health_____

Do you have any problems with any of the following systems? (please circle yes or no)

Gastrointestinal	yes/no	Nervous	yes/no	Endocrine (glands)	yes/no
Ear/Nose/Throat	yes/no	Urinary	yes/no	Blood/Lymph	yes/no
Cardiovascular	yes/no	Eyes	yes/no	Allergic/Immunologic	yes/no
Respiratory	yes/no	Headaches	yes/no	Integumentary (skin)	yes/no
High blood pressure	yes/no	Mental	yes/no	Muscles/Bone	yes/no

If yes to any please explain_____

Do you have Diabetes? yes/no Type _____Date of diagnosis_____ Last HbA1c (if known)_____

Allergies to medication? yes/no Which?_____ Reactions_____

Other health problems?_____

List current medication(s) ☐check if none_____

Do you smoke? yes/no If female, are you pregnant or nursing? yes/no _____

Please list any operations you have had with their dates_____

Name of family doctor_____ Last visit_____

Personal Eye Information

Date of last eye exam_____ Were you dilated? yes/no

Have you ever been diagnosed with any of the following?:

Macular Degeneration	yes/no	Glaucoma	yes/no	Diabetic Retinopathy	yes/no
Retinal detachment	yes/no	Cataracts	yes/no	Hypertensive Retinopathy	yes/no

Do you have dry eyes? yes/no History of eye injury? yes/no Kind?_____Date?_____

Historyofeye surgery? yes/no Type_____ Date_____

Do you wear glasses? yes/no Contact lenses? yes/no Type/Brand_____

How many hours a day are you on the computer?_____ Do you have eyestrain as a result? yes/no

Additional vision/eye health information:_____

Family Medical and Eye Health 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_____

For Return Patients Only

If no changes to report for the year please intital/date

Initial _____ Date _____

Initial _____ Date _____

If you have new changes to report please provide them in the designated space below:

_____ Date: _____

_____ Date: _____

Doctor Use Only

Reviewed by:_____ Date_____

_____ _____

_____ _____