



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? _____

History of eye 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 intial/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 _____

