PATIENT HISTORY QUESTIONNAIRE

Date_____ Name_____ Birthdate _____ M_ F_

Occupation/Employer/School Grade _____ Hobbies _____

Date of last eye exam _____ Where was your last exam? _____

Have you ever had any:
Eye operations? Y N
If yes, type & date:_____
Eye, head, neck or back injuries? Y N
If yes, type & date:_____

Do you have any of the following?

Glaucoma	Y N	Cataracts	Y N	Macular degeneration	Y N
Dry eyes	Y N	Red eyes	Y N	Double vision	Y N
Itchy eyes	Y N	Watery eyes	Y N	Flashes or floating spots	Y N

Do you wear glasses? Y N Contact lenses? Y N

Are you interested in:
Contact lenses? Y N Sunglasses? Y N Computer glasses? Y N Laser Surgery? Y N

MEDICAL INFORMATION

Family doctor _____ Ph # (if known)_____ Date of last visit _____

Do you have problems with any of the following systems?

Gastrointestinal	Y N	Musculoskeletal	Y N	Neurological	Y N	Ear/Nose/Throat	Y N
Genitourinary	Y N	Psychiatric	Y N	Cardiovascular	Y N	Respiratory	Y N
Skin	Y N	Allergic/Immune	Y N	Blood/Lymph	Y N	Endocrine (Glands)	Y N

Please explain_____

Are you pregnant or nursing? Y N

Do you have any of the following conditions?
Diabetes Y N Type _____ High blood pressure Y N HIV / AIDS Y N
Hepatitis Y N Headaches Y N Migraines Y N

Please list any medications (prescription or non-prescription) you are taking_____
_____

Please list any prescription eye drops you are taking_____

Are you allergic to any medications? Y N If yes, please list_____
_____

Do you use cigarettes? Y N Tobacco? Y N Alcohol? Y N Recreational Drugs? Y N

What other substances do you use? _____

FAMILY HEALTH HISTORY

Does anyone in your family have the following conditions? If yes, please write their relation below.

High Blood Pressure	Y N	Thyroid Disease	Y N	Diabetes	Y N	Heart Disease	Y N
Multiple Sclerosis	Y N	Cancer	Y N	Glaucoma	Y N	Cataracts	Y N
Retinal Detachment	Y N	Macular Degeneration	Y N	Other_____			