

**Patient History Questionnaire**

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Name of Spouse/Partner \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_ SSN \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer or School & Grade \_\_\_\_\_  
Emergency Contact (Name & Phone Number) \_\_\_\_\_  
E-mail Address \_\_\_\_\_

**Responsible Party or Insured**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Employer \_\_\_\_\_  
Work Phone # \_\_\_\_\_ Vision Insurance \_\_\_\_\_  
Medical Insurance \_\_\_\_\_ SSN of insured \_\_\_\_\_

**If patient is a child under the age of 18 please complete this section below**

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_  
Address \_\_\_\_\_ Address \_\_\_\_\_  
Telephone \_\_\_\_\_ Telephone \_\_\_\_\_  
Child lives with:  Both Parents  Mother  Father  Other \_\_\_\_\_

Date of last exam (if not performed here) \_\_\_\_\_ Dilated? \_\_\_\_\_  
Have you had any eye operations?  Y  N Type \_\_\_\_\_ Date \_\_\_\_\_  
Have you had any eye injury?  Y  N Describe \_\_\_\_\_ Date \_\_\_\_\_  
Do you have glaucoma?  Y  N Cataracts?  Y  N Dry Eyes?  Y  N Blurred vision?  Y  N  
Do you wear glasses?  Y  N Do you wear contact lenses?  Y  N What type? \_\_\_\_\_  
What date did you begin wearing contact lenses? \_\_\_\_\_ Type of solution \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

**General health conditions can sometimes affect your vision or ocular health. Please complete as much of this section as you feel comfortable with, or discuss these issues with you doctor during your examination.**

Do you have problems with any of these systems?  
Eyes  Y  N                      Gastrointestinal  Y  N                      Nervous  Y  N  
Ears/Nose/Throat  Y  N                      Genitourinary  Y  N                      Endocrine (glands)  Y  N  
Cardiovascular  Y  N                      Musculoskeletal  Y  N                      Blood/Lymph  Y  N  
Respiratory  Y  N                      Allergic Immunologic  Y  N                      HIV / Aids  Y  N  
Mental/ Nervous  Y  N                      Integumentary/skin  Y  N  
Please explain any Yes answers \_\_\_\_\_  
How would you describe your general health? \_\_\_\_\_

**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? \_\_\_\_\_ Headaches  Y  N How often? \_\_\_\_\_  
Other health problems? \_\_\_\_\_  
Current medications \_\_\_\_\_  
Have you had any operations?  Y  N Specify type and date \_\_\_\_\_  
Do you use cigarettes/tobacco?  Y  N Alcohol?  Y  N Other substances?  Y  N  
Name of family doctor \_\_\_\_\_ Date of last visit \_\_\_\_\_ Date of last tetanus shot \_\_\_\_\_

**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 \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_ Doctor's initials \_\_\_\_\_