Patient History Questionnaire

Today's Date

Print Form

IMPORTANT: This questionnaire is to be reviewed at each appointment. Save as PDF, fill it out and PRINT to bring to your appointment. Please answer all questions.

Last Name | First Name | MI

Address | City | State AL | Zip

Work Number | Home Number

Date of Birth | Occupation | Employer

Emergency Contact Name | Phone Number

Date of Last Eye Exam | Dilated? ☐ YES ☐ NO | Referred By

Primary Vision Coverage | Secondary Coverage

MEDICAL INFORMATION

How is your general health?

Do you take medications for any of these symptoms? (Please select YES or NO)

Gastrointestinal	☐ YES	☐ NO	Nervous	☐ YES	☐ NO	Endocrine (glands)	☐ YES	☐ NO
Ears/Nose/Throat	☐ YES	☐ NO	Urinary	☐ YES	☐ NO	Blood/Lymph	☐ YES	☐ NO
Cardiovascular	☐ YES	☐ NO	Muscles/Bones	☐ YES	☐ NO	Allergic/Immunologic	☐ YES	☐ NO
Respiratory	☐ YES	☐ NO	Integumentary (skin)	☐ YES	☐ NO	Headaches	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO	Eyes	☐ YES	☐ NO	Mental	☐ YES	☐ NO

Please explain: | Diabetes ☐ YES ☐ NO | Type | Date of Diagnosis

Allergies to medication? ☐ YES ☐ NO | Which? | Reactions?

Other health problems

Current medication(s)

Have you had any operations? ☐ YES ☐ NO | What kind? | Date

Name of family doctor and/or primary care physician

Date of last visit | Date your blood pressure was last checked

FAMILY 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	

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems?	☐ YES	☐ NO	What kind?								
Have you had any eye operations?	☐ YES	☐ NO	What type?		Date						
Have you had an eye injury?	☐ YES	☐ NO	What kind?		Date						
Do you have glaucoma?	☐ YES	☐ NO	Cataracts?	☐ YES	☐ NO	Dry eyes?	☐ YES	☐ NO
Macular degeneration?	☐ YES	☐ NO	Retinal detachment?	☐ YES	☐ NO	Blurred vision?	☐ YES	☐ NO
Do you wear glasses?	☐ YES	☐ NO	Contact lenses?	☐ YES	☐ NO	What type?		

DOCTOR USE ONLY

Reviewed by | ◯ No changes | Date

Reviewed by | ◯ No changes | Date

Reviewed by | ◯ No changes | Date

Reset Form