Patient History Questionnaire

NAME*_____*DATE __/__/____

CELL PHONE# _____ ____ ***Date of Birth*** ___/__/__

***Home#*_____ *Work#*_____**

***EMail*_____**

_____

Medical History

How is your general health? _____ Are you a smoker? _____

Do you have problems with any of the following? (Circle All That Apply)

Disorder		**Specific Diagnosis**	**Medication To Treat**
Allergies	*Y/N*	*Allergies-*	
Cancer	*Y/N*		
Blood/Lymph	*Y/N*		
Cardiovascular(Heart, high blood pressure/hypertension,other)	*Y/N*		
DIABETES	*Y/N*	*Type____/date diag_____*	
Ears/Nose/Throat	*Y/N*		
Endocrine(Glands)	*Y/N*		
Gastrointestinal(Stomach,Colon)	*Y/N*		
Integumentary(Skin)	*Y/N*		
Mental Disorder/Anxiety	*Y/N*		
Nervous System	*Y/N*		
Respiratory(Lungs)	*Y/N*		
Musculoskeletal(Bones/Muscle)	*Y/N*		

Headaches Y/N Duration_____Frequency_____ Location_____Onset_____

Medication Allergies **(Please note reaction to medication)**

Medication	**Reaction**

Over The Counter Medications (ex. Tylenol-for headaches)

_____

_____

Surgical History (List general surgeries and eye surgeries)

Procedure	**Date**
Example- Lasik	***MM/DD/YYYY***

Ocular(Eye) History

Disorder		***Specific Diagnosis***	***Medication To Treat***
Allergies	*Y/N*		
Blurred Vision	*Y/N*		
Injury	*Y/N*		
Cataracts	*Y/N*		
Dry Eyes	*Y/N*		
Eyes Itch	*Y/N*		
Glaucoma	*Y/N*		
Redness	*Y/N*		
Water	*Y/N*		
Other	*Y/N*		

Family Health History

Disorder	***Relation(ex. Mother or* Maternal *Grandmother)***	***Disorder***	***Relation(ex. Mother or* Maternal *Grandmother)***
Cataracts		Cardiovascular(Heart)	
Color Blindness		Diabetes- *Type*____	
Glaucoma		*Hypertension (High Blood Pressure)*	
Macular Degeneration		*Other(Medical)-*	
Retinal Detachment		*Other(Ocular)-*	

Additional Information_____

_____

DATE OF LAST PHYSICAL_____**Physician**_____

DATE OF LAST EYE EXAM_____**Physician**_____

Today's Date _____ _____ _____ _____

_____ _____ _____ _____ _____