Patient History Questionnaire

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Today's Date_____Referred By_____
Patient Name_____Email Address_____
Street Adress_____
City, State, and Zip Code_____
Home Phone: ( )_____Cell Phone ( )_____
Age_____Birth Date_____Sex_____Single_____Married_____Other_____
Occupation_____SSN #_____

Primary Vision Coverage_____Policy/Group#_____
Insured's Name_____Insured's SSN #_____
Insured's Birth Date_____Insured's Employer_____

What is you general health?

Do you have any problems with any of these systems? (Please circle **Y** or **N**)

Gastrointestinal	Y/N	Nervous	Y/N	Endocrine (glands)	Y/N
Urinary	Y/N	Ears/Nose/Throat	Y/N	Blood/Lymph	Y/N
Cardiovascular	Y/N	Muscles/bones	Y/N	Allergic/Immunologic	Y/N
Respiratory	Y/N	Integumentary	Y/N	Headaches	Y/N
High Blood Pressure	Y/N	Eyes	Y/N	Mental	Y/N

Please Explain_____
Diabetes Yes/No Type_____Date of Dianosis_____
Medications:_____
Allergies:_____
Have you had any operations? Yes/No Kind?_____When?_____
Name of Family Doctor_____Date of last Physical_____
Family Doctor Phone ( )_____Date of last tetanus shot_____

Family History: (Please circle Y or N)

High Blood Pressure	Y/N Relation:_____	Diabetes	Y/N Relation:_____
Macular Degeneration	Y/N Relation:_____	Glaucoma	Y/N Relation:_____
Retinal Detachment	Y/N Relation:_____	Cataracts	Y/N Relation:_____

Eye History: (Please circle Y or N) Date of last Eye Exam_____

Glaucoma	Y/N	Cataracts	Y/N	Dry eyes	Y/N
Macular Degeneration	Y/N	Retinal Detachment	Y/N	Blurred vision	Y/N
Do you wear glasses	Y/N	Do you wear contacts	Y/N	Type of contacts	_____

Do you have any eye conditions or problems? Y/N What kind?_____
Have you had any eye operations? Y/N Type_____Date_____
Have you had an eye injury? Y/N Type_____Date_____
What do you like to do at your spare time?_____

Responsible Party's Signature_____