PATIENT HISTORY QUESTIONNAIRE

Patient _____
Last Name First Name Middle Name

Social Security# _____ Date of Birth _____ Email _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____ Employed by _____

MEDICAL INFORMATION

Reason for visit/chief complaint _____

Name of family doctor _____ Date of last physical _____

Do you have problems with any of these systems? Please circle all that apply.

Mental	Y	N	Respiratory	Y	N	Musculoskeletal	Y	N	Endocrine	Y	N
Ear/Nose/Throat	Y	N	Gastrointestinal	Y	N	Integumentory [skin]	Y	N	Blood/Lymph	Y	N
Cardiovascular	Y	N	Genitourinary	Y	N	Nervous	Y	N	Allergic/Immunologic	Y	N

Please Explain _____

Please answer all that apply:

Diabetes	Y N	Type _____	Date of diagnosis _____		
Allergies	Y N	To what? _____	Symptoms _____		
Medicine allergies	Y N	To what? _____	Symptoms _____		
Headaches	Y N	How often? _____	Relieved by _____		

Current medications/vitamins _____

Have you had any operations? Y N Condition _____ Date _____

Do you use tobacco products? Y N Packs per day _____ Vape Y N Alcohol Y N Amount _____

Other Substances _____

FAMILY MEDICAL 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 condition	Y	N	_____				

PERSONAL EYE INFORMATION

Do you wear glasses? Y N Contact lenses? Y N Brand _____ Solution brand _____

Do you have: Blurred vision Y N At far/close with contacts Y N with glasses Y N

Dry eyes Y N Cataracts Y N Glaucoma Y N

Other eye conditions _____

Have you had any eye operations? Y N Type _____ Date _____

Have you had any eye injury? Y N Describe _____

Patient's signature _____ **Date** _____

Doctor's signature _____ **Date** _____