

PATIENT HISTORY QUESTIONNAIRE

Name: _____ Date: _____
Occupation: _____ Primary Physician: _____
Date of last eye exam: _____ Eye Insurance: _____
Who may we thank for referring you? _____

The following information is required by Medicare and most health care carriers. Please answer all appropriate questions.

Eye Information

Primary reason for appointment: _____
Do you regularly wear glasses? _____ Contact lenses? _____ Type _____
What solutions do you use? _____ Years wearing contacts? _____
Are you satisfied with the comfort and vision? _____ Interested in contact lenses? _____
Have you had any eye surgery or injury? _____ Type _____ Date _____
Do you have: ___ Glaucoma ___ Cataracts ___ Dry Eyes ___ Blurred Vision
___ Pain ___ Redness ___ Itching ___ Burning ___ Poor Night Vision
___ Tearing ___ Flashes ___ Floaters ___ Eye Turn ___ Double Vision
___ Discharge ___ Light Sensitivity
Do you: ___ Use a computer? ___ Experience problems with glare or reflections?
___ Spend a lot of time outdoors? ___ Have hobbies where eye safety is a concern?
Do you have any other special hobbies or sports activities? _____
Have you considered laser surgery? _____ Are you licensed to drive? _____
Please explain any other eye or visual conditions? _____

General Health Information

How is your general health? _____
List any medications you are taking: _____

Do you have any problems with any of the following?

- ___ Allergic ___ Gastrointestinal ___ Nervous
- ___ Ears/Nose/Throat ___ Genitourinary ___ Endocrine (glands)
- ___ Cardiovascular ___ Musculoskeletal ___ Blood/Lymph
- ___ Respiratory ___ Integumentary(skin) ___ Immune/Lupus/HIV

Please explain: _____

___ Are you pregnant or nursing? _____
___ Diabetes, Type _____ Date of diagnosis _____ Last BS or A1C _____
___ High Blood Pressure, Controlled? _____ Date of diagnosis _____
___ Medication Allergy, What happens? _____
___ Allergies, To what? _____ What happens? _____
___ Headaches or migraines, Location on head? _____ How often? _____
___ Operations, What kind? _____ When? _____

Do you use ___ cigarettes/ tobacco ___ alcohol ___ other substances?

Date of last physical exam by primary physician? _____

Family History

High Blood Pressure _____ Relation _____ Diabetes _____ Relation _____
Macular Degeneration _____ Relation _____ Glaucoma _____ Relation _____
Retinal Detachment _____ Relation _____ Cataracts _____ Relation _____
Other Eye Conditions _____ Relations _____

Reviewed by:

Doctor: _____ Date: _____ Doctor: _____ Date: _____ Doctor: _____ Date: _____
Doctor: _____ Date: _____ Doctor: _____ Date: _____ Doctor: _____ Date: _____
Doctor: _____ Date: _____ Doctor: _____ Date: _____ Doctor: _____ Date: _____
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