

PATIENT HISTORY QUESTIONNAIRE  
(must be updated at each visit)

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

**PERSONAL EYE INFORMATION**

Have you had any eye operation? NO \_ YES \_ Type \_\_\_\_\_ Date \_\_\_\_\_  
Have you had any eye injury? NO \_ YES \_ Type \_\_\_\_\_ Date \_\_\_\_\_  
Do you have glaucoma? NO \_ YES \_  
Do you have cataract? NO \_ YES \_  
Do you have dry eyes? NO \_ YES \_  
Do you have blurred vision? NO \_ YES \_  
Additional information \_\_\_\_\_

Whom do we thank for referring you? \_\_\_\_\_

**MEDICAL INFORMATION**

Do you have problems with any of these systems?

Eyes	NO _	YES _	Cardiovascular	NO _	YES _
Respiratory	NO _	YES _	Integumentary (skin)	NO _	YES _
Mental	NO _	YES _	Gastrointestinal	NO _	YES _
Nervous	NO _	YES _	Genitourinary	NO _	YES _
Blood/Lymph	NO _	YES _	Musculoskeletal	NO _	YES _
Ear/Nose/Throat	NO _	YES _	Endocrine (glands)	NO _	YES _
Allergic	NO _	YES _			

/Immunologic

Please

explain \_\_\_\_\_

**Please answer all that apply:**

Diabetes NO \_ YES \_ Type \_\_\_\_\_  
Headaches NO \_ YES \_  
Allergies NO \_ YES \_ Type \_\_\_\_\_ Symptoms \_\_\_\_\_  
Medication NO \_ YES \_ Type \_\_\_\_\_ Symptoms \_\_\_\_\_  
-allergy

Have you had any operations? NO \_ YES \_ Type \_\_\_\_\_ Date \_\_\_\_\_

Current medication (s) NO \_ YES \_ Type \_\_\_\_\_

Do you use: Cigarettes/Tobacco, Alcohol or other substance? NO \_ YES \_ Type \_\_\_\_\_

**FAMILY HISTORY**

High blood pressure	NO _	YES _	Relation	_____
Macular degeneration	NO _	YES _	Relation	_____
Diabetes	NO _	YES _	Relation	_____
Retinal detachment	NO _	YES _	Relation	_____
Glaucoma	NO _	YES _	Relation	_____
Cataracts	NO _	YES _	Relation	_____
Other eye conditions	NO _	YES _	Relation	_____ Type _____

**Doctor's comments:**

Doctor's signature \_\_\_\_\_

Today's date \_\_\_\_\_