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 Diagnosis____________________
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____