PATIENT HISTORY QUESTIONNAIRE

Last Name: ______________________ First Name: ______________________ MI: ________

Address: ______________________ City, State, & Zip Code: ______________________

Date of Birth: ______________ Home Tel# ______________ Cell # ______________

Gender: Male Female Other Email: ______________________ SSN # (last 4) ______________

Occupation: ______________________ Employer: ______________________

Family Doctor: ______________________ Date of Last visit: __________ How did you hear about us? __________

Date of **Last Eye Exam**: ______________ Doctor ______________________

Medication(s): (Please list including over the counter)

Do you have any **medical allergies**? Yes No If yes, please list: ______________________

Do you use **cigarettes/tobacco**? Yes No **Alcohol?** Yes No **Other Substances**? Yes No

Have you had any recent **surgery**? Yes No If yes, Please list: ______________________

Are you **pregnant** or **breastfeeding**? Yes No

Please Circle **Yes** or **No** to the following:

YOUR EYE and MEDICAL HISTORY

Allergic/Immunologic	Yes	No	Gastrointestinal	Yes	No
Blood/Lymph	Yes	No	Headaches	Yes	No
Blurred Vision	Yes	No	Integumentary (skin)	Yes	No
Cardiovascular	Yes	No	Muscles/bones	Yes	No
Ears/Nose/Throat	Yes	No	Neurological (Stroke)	Yes	No
Endocrine (glands)	Yes	No	Respiratory	Yes	No
Eyes	Yes	No	Urinary	Yes	No

FAMILY EYE and HEALTH HISTORY

(Relationship = Father, Mother, Brother, Sister, Grandparent)

	Yourself		**Family Members**		**Relationship**				
Cataracts	Yes	No	Yes	No	F	M	B	S	GP
Glaucoma	Yes	No	Yes	No	F	M	B	S	GP
Macular Degeneration	Yes	No	Yes	No	F	M	B	S	GP
Retinal Detachment	Yes	No	Yes	No	F	M	B	S	GP
High Blood Pressure	Yes	No	Yes	No	F	M	B	S	GP
Diabetes	Yes	No	Yes	No	F	M	B	S	GP

Do you have any eye conditions or problems not listed above? Yes No If yes, Please explain? ______________

Have you had an eye injury? Yes No If yes, Please explain: ______________________

Have you had any eye surgery? Yes No If yes, Please list: ______________________

By signing this form, I consent to treatment for myself and/or on the behalf of the Minor for which this information pertains. I give permission for the doctor(s) to examine, diagnose and initiate treatment as deemed appropriate. I further attest that I am the Parent or Legal Guardian of the Minor and have the authority to authorize care and treatment.

______________________ ______________

Patient or Guardian Signature Date