PATIENT HISTORY QUESTIONNAIRE

OFFICE USE:

Last Name: _____ **Today's Date**: _____

First Name: _____ **Nickname**: _____

MEDICAL INFORMATION

What is your general health?_____

Do you have problems with any of these systems? (please circle all that apply)

Gastrointestinal	Y / N	Nervous	Y / N	Mental	Y / N
Ear/Nose/Throat	Y / N	Genitourinary	Y / N	Endocrine (glands)	Y / N
Cardiovascular	Y / N	Musculoskeletal	Y / N	Blood/Lymph	Y / N
Respiratory	Y / N	Integumentary (skin)	Y / N	Allergic/Immunologic	Y / N

Please explain _____

(Please answer all that apply):

Diabetes Y / N Type _____ Date of Diagnosis_____

Allergies Y / N Allergic to what? _____

What happened? _____

Medication allergy Y / N What happened? _____ Headaches Y / N

Other health problems _____

Current medication(s) _____

Have you had any operations? Y / N Kind? _____

When? _____ Date of last tetanus shot _____

Do you use cigarettes/tobacco? Y / N Alcohol? Y / N Other substance(s)? Y / N What? _____

Name of family doctor _____ Date of last visit: _____

PERSONAL EYE INFORMATION

Have you had any eye operations: Y / N Type _____ Date _____

Have you had any eye injuries? Y / N Kind _____ Date _____

Do you have glaucoma? Y / N Cataracts? Y / N Dry Eyes? Y / N Blurred Vision? Y / N

Other eye problems? Y / N What kind? _____

FAMILY 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(s): Y / N What kind? _____