

Patient History Questionnaire

Name: _____ Date: _____

Systemic Medical History

Name of family doctor _____ Date of last visit _____

List any current systemic medications and reason for taking: _____

List any medication allergies: _____

List any recent operations: _____

Ocular History

Approximate date of last dilated eye exam _____ Doctor _____

Circle which you have: Blurred vision Cataracts Dry Eyes Eye allergies Flashes Floaters
Eye allergies Glaucoma Other: _____

List any current eye medications you take: _____

List any eye surgeries, infections, or injuries: _____

Social History

Circle which you use: Cigarettes/tobacco Alcohol Frequently Narcotics

Immediate Family History

List any major family medical problems: _____

Circle which eye conditions run in the family: Cataracts Glaucoma Macular Degeneration
Retinal Detachment

List other Family Eye Diseases: _____

Vision Rx History

Circle which apply: Use glasses Need safety glasses
Use contacts Sleep in Contacts
Have glare while driving Use computer often Interested in LASIK

What task do you use your eyes for most of the day? _____

What contact brand and power do you use if you have contacts: _____

Review of Systems

Circle any body systems that you have current problems with:

Allergy	Gastrointestinal (Digestion)	Muscle/Skeleton
Cardiovascular (Heart/Blood Vessels)	Reproductive/Urinary	Neurological (Brain/Nerves)
Constitutional	Blood/Lymph	Mental (Psychiatric)
Cranial / Facial	Immune System	Respiratory (Lungs)
Endocrine (Glands)	Integumentary (Skin)	Cancer Hx

Please explain any circled. _____

If Diabetes, Type _____ Date of diagnosis _____ Avg. Blood Sugar range _____ A1C _____

Reviewed: _____