Patient History Questionnaire

Name: _____________________________ Date: ________________

(Gov’t use: Race:____ Ethnicity ______ Preferred Language ______ Ht____ Wt____ Sex: M/F)

Systemic Medical History

Name of family doctor _______________________________ Date of last visit __________
List any current systemic medications and reasons for each:_________________________________________________________

List any medication allergies and what happens for each:_________________________________________________________

List any recent operations: ___________________________________________________________________________________________________

Pharmacy Name and address if known_______________________________________________________

Ocular History

Approximate date of last dilated eye exam _________ Doctor __________________________
Circle which you have: Blurred vision Cataracts Dry Eyes Eye allergies Flashes Floaters
Macular Degeneration Glaucoma Other:_________________________________________________________

List any current eye medications you take:____________________________________________________________________________________________
List any eye surgeries, infections, or injuries:________________________________________________________________________________________

Social History

Complete if use: Cigarettes/tobacco __ How Much ______ Alcohol __ Frequency _____ Dependence Y / N
Past cigarette/tobacco use_____ Narcotics Use _____

Immediate Family History

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 Use contacts Sleep in contacts Need safety glasses
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: _________