Patient History Questionnaire

Revision B

Name: _____
(Gov't use: Race:_____ Ethnicity _____ Preferred Language _____ Ht_____ Wt____Sex: M/F)

FOR RETURNING PATIENTS ONLY: I attest that there are no changes to my social, medical, or ocular history since the date of my last PATIENT HISTORY QUESTIONNAIRE. I have the same primary care physician and medications, no new medication allergies, and do not have any new medical or ocular conditions. Initial ____ and sign at the bottom of the form.

Systemic Medical History

Circle any that you have problems with currently:

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_____

Current systemic medications: _____
_____
_____ **Or See Attached List: Yes No**
Medication allergies: _____
_____
Pharmacy Name and location:_____
Family Doctor:_____

Ocular History

Eye Conditions – Circle which apply: Blurred Vision Cataract Dry Eye Eye Allergy Floaters Glaucoma Macular Degeneration Tired Eyes **Other:**_____
_____
Current Eye Medications:_____
Eye Surgeries, Infections, Injuries, etc: _____
Vision Correction Needs/Problems - Circle which apply: Use Glasses Use Contacts Glare Driving Use Computer Often Need Safety Glasses Headache Other:_____
What task do you use your eyes for most of the day?_____
Contact Brand: _____ Power: OD: _____ OS: _____
New Patient Only: Approximate date of last dilated eye exam _____ **Doctor** _____

Social History

Cigarettes or tobacco use, current or past: Yes No

Immediate Family History

List Major Family Medical Problems: _____
Circle Family Eye Conditions: Cataract Glaucoma Macular Degeneration Retinal Detachment
Other: _____

Signed: _____ **Date: _____**