Patient History Questionnaire

PATIENT'S NAME :(LAST)_____(FIRST)_____
ADDRESS: _____
CITY:_____STATE:_____ZIP CODE:_____
HOME PHONE#_____WORK PHONE# _____
CELL PHONE:_____E-MAIL_____
MARITAL STATUS: SINGLE ☐ MARRIED ☐ LEGALLY SEPARATED ☐ DIVORCED ☐ WIDOWED ☐
OCCUPATION_____EMPLOYER_____
DRIVER LICENSE#_____EXP. DATE_____
SOCIAL SECURITY_____GENDER: FEMALE ☐ MALE ☐
DATE OF BIRTH:_____CURRENT DATE:_____

HOW IS YOUR GENERAL HEALTH?_____

PLEASE ANSWER ALL THAT APPLY:
DIABETES YES/NO TYPE_____ DATE OF DIAGNOSIS_____
ALLERGIES YES/NO ALLERGIES TO WHAT? _____
MEDICATION?_____HEADACHES YES/NO
OTHER PROBLEMS? _____
HAVE YOU HAD ANY OPERATIONS? YES/NO KIND_____WHEN _____
DO YOU SMOKE?_____ALCOHOL _____

Family History

HIGH BLOOD PRESSURE	**YES / NO**	**RELATION**_____
DIABETES	**YES / NO**	**RELATION**_____
RETINAL DETACHMENT	**YES / NO**	**RELATION**_____
GLAUCOMA	**YES / NO**	**RELATION**_____
MACULAR DEGENERATION	**YES / NO**	**RELATION**_____
CATARACTS	**YES / NO**	**RELATION**_____
OTHER EYE CONDITIONS	**YES / NO**	**RELATION**_____

Personal Eye Information

HAVE YOU HAD ANY OPERATION? YES/NO TYPE_____DATE_____
HAVE YOU HAD ANY INJURY? YES/NO KIND _____DATE_____
GLAUCOMA YES/NO CATARACTS YES/NO DRY EYES YES/NO BLURRY VISION YES/NO
DO YOU WEAR GLASSES? YES/NO CONTACT LENSES YES NO TYPE _____
OTHER EYE CONDITION? YES/NO WHAT KIND?_____
REFERRED BY_____DOCTOR'S INITIALS_____