PATIENT HISTORY QUESTIONNAIRE

Please complete the following. If you have any questions, we would be happy to assist you.

First Name _____ MI _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Employer _____ Occupation _____

Insured Party's Name & Date of Birth _____ Last 4 digits of party's SSN # _____

Emergency Contact & Phone # _____

Name of Primary Care Physician _____ Referred By _____

Email Address _____

Please check any of the following that you would like more information about? ☐ Glaucoma ☐ Cataract ☐ Dry Eye

☐ Macular Degeneration ☐ Diabetic Eye Disease ☐ Floaters & Flashes ☐ LASIK ☐ Contact Lenses ☐ Latisse

MEDICAL INFORMATION

What is your general health? _____

Do you have problems with any of these systems?

Gastrointestinal	Y/N	Genitourinary	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Musculoskeletal	Y/N	Endocrine (glands)	Y/N
Cardiovascular	Y/N	Integumentary (Skin)	Y/N	Blood/lymph	Y/N
Respiratory	Y/N	Mental	Y/N	Allergic/immunologic	Y/N

Please explain? _____

Diabetes? Y/N Type _____ Date of Diagnosis _____ HIV? Y/N Date of Diagnosis _____

Allergies? Y/N Allergic to what? _____ What happens? _____

Medication Allergies? Y/N What Medication(s)? _____ What happens? _____

Headaches? Y/N High Blood Pressure? Y/N Are you pregnant or breastfeeding? Y/N

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

Date of Last Tetanus Shot? _____ Other health problems? _____

Current Medication(s) _____

FAMILY/SOCIAL HISTORY

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, glaucoma, macular degeneration)? Y/N

If so, please explain: _____

Do you use tobacco products? _____ How much? _____ Do you drink alcohol? _____ How much? _____

PERSONAL EYE INFORMATION

Reason for today's visit? _____

Do you wear glasses? Y/N Do you wear contact lenses? Y/N

Are you currently experiencing any eye symptoms? Please check all that apply:

Eye Pain ☐	Blurred Vision ☐	Eyelid Crusting ☐	Flashes of Light ☐	Halos ☐
Discharge ☐	Light Sensitivity ☐	Double Vision ☐	Decreased Vision ☐	Floaters ☐

Have you ever been diagnosed with an eye disease? Y/N Please list condition, which eye, and date of diagnosis: _____

Have you ever had an eye injury? Y/N If so, please describe: _____

Have you ever had eye surgery? Y/N Please list type, which eye, and dates: _____

Are you currently using any eye medications? Please list name(s) and how often used: _____

_____ _____

Patient/Guardian Signature Date Doctor's Initials Date