Patient History Questionnaire

Today's Date ________________________

Name (Last, First): _________________________________ , __________________________________ Sex: ☐ Male ☐ Female

Birthdate: ____________________ Occupation: ______________________________ Date of Last Eye Exam: ______________

Address: ___________________________________ City: _____________________ State: ________ Zip Code:_____________

Email: ____ Cell Phone: ____

Emergency Contact Name: ____________________________________ Phone Number: _______________________________

Vision Insurance: _____________________ Primary Member Insured / ID number: ______________________________________

Medical Information

Do you have any of the following? **(Please check if applicable)**.

☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Disease ☐ Diabetes

☐ Asthma ☐ Allergies ☐ Thyroid Disorder ☐ Migraines

Other conditions (please specify): ____

Allergies to medication: ☐ Yes ☐ No (please specify if yes): ____

Current medication(s): ____

Name of primary care physician: _______________________________________ Date of last visit : _______________________

Family History

Is there a family history of any of the following? **(Please check if applicable)**.

☐ High Blood Pressure Relation ____________________ ☐ Macular Degeneration Relation ______________________

☐ High Cholesterol Relation ____________________ ☐ Glaucoma Relation ______________________

☐ Diabetes Relation ____________________ ☐ Retinal Detachment Relation ______________________

Personal Eye Information

Do you have a history of any of the following? **(Please check if applicable)**.

☐ Glaucoma ☐ Macular Degeneration ☐ Retinal detachment ☐ Cataracts

☐ Eye operations (please specify):___________________________ ☐ Eye injury (please specify):_______________________

☐ Glasses ☐ Contact lenses (please specify type/brand): ____

Doctor Use Only

Reviewed by ____ Date _________________________________

Reviewed by ____ Date _________________________________

Reviewed by ____ Date _________________________________