PATIENT HISTORY QUESTIONNAIRE

DATE_____

Name_____ Birthdate_____

Do you have health problems in any of these areas? Please circle all that apply.

Gastrointestinal (stomach, intestines)	Y/N	Nervous	Y/N	Mental health	Y/N
Ear/nose/throat	Y/N	Urinary	Y/N	Thyroid/endocrine	Y/N
Cardiovascular	Y/N	Muscles/bones	Y/N	Blood/lymph	Y/N
Respiratory/Breathing/Lungs	Y/N	Skin	Y/N	Allergies	Y/N

Please explain any "Yes" responses from above

_____

Please answer all that apply, below:

Diabetes Y/N Year of diagnosis _____ High blood pressure Y/N Year of diagnosis _____

Medication allergies _____

Current medications

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____

Have you had any surgeries? Y/N Explain _____

Do you use tobacco? Y/N Type and frequency_____

Name of family doctor? _____

FAMILY HISTORY

Diabetes Y/N Relation _____ Macular degeneration Y/N Relation _____

Glaucoma Y/N Relation_____ Retinal detachment Y/N Relation _____

Lazy eye Y/N Relation_____

Other eye conditions? _____

PERSONAL EYE HISTORY

Occupation _____

Have you had any eye operations? Y/N Type and year _____

Have you had any eye injuries? Y/N Kind and year_____

Do you have glaucoma? Y/N

Do you have dry eyes? Y/N

Do you wear contact lenses? Y/N Soft or Rigid? Age of current lenses_____

If Soft, how often do you replace your lenses?_____

Whom may we thank for referring you?_____

Patient signature _____

E-mail_____