Patient History Questionnaire

Last Name_____ First Name_____ Date_____ DOB: _____

Email address:_____ Phone number:_____

PERSONAL INFORMATION

1. What is the reason for your visit? _____

☐Routine eye exam ☐Decreased vision distance / near / both ☐Red Eye ☐Foreign object ☐Contact lens fit

2. When was your last eye exam? _____
3. Have you had any eye injuries? ☐No ☐Yes
   a. Type of injury_____ When did it happen? _____
4. Have you had any eye operations? ☐No ☐Yes
   Type of Operation_____ When was it done? _____
5. Have eyeglasses ever been prescribed for you? ☐No ☐Yes
   Do you wear eye glasses now? ☐No ☐Full time ☐Part Time ☐Lost ☐Broken ☐Stolen
6. Have contact lenses ever been prescribed for you? ☐No ☐Yes
   Do you wear contact lenses now? ☐No ☐Full time ☐Part time
   Type and power of contact lenses_____
7. Please check any eye problems you have or previously had: If none check ☐ N/A

☐Crossed eyes	☐Cataracts	☐Skin	☐Endocrine (glands)	☐Floaters
☐Double Vision	☐Glaucoma	☐Seeing Flashes	☐Loss of Vision	
☐Amblyopic (lazy eye)	☐Macular Degeneration	☐Retinal detachment	☐Other eye disease	

PERSONAL HEALTH HISTORY

1. Do you have problems with any of the following? If none check ☐ N/A

☐Ears/nose/throat	☐Gastrointestinal	☐Skin	☐Endocrine
☐Cardiovascular	☐Genitourinary	☐Immune System	☐Blood/Lymph
☐Respiratory (breathing)	☐Musculoskeletal	☐Nervous System	☐Mental health

2. Have you been diagnosed with any of the following? If none check ☐ N/A

☐Diabetes ☐Hypertension ☐Rheumatoid arthritis ☐Stroke ☐Others

When was it diagnosed? _____
Is it controlled?_____

3. Are you taking any medications? ☐No ☐Yes, Please list them: _____
   _____
4. Are you allergic to any medications? ☐No ☐Yes, Please list them: _____
   _____
5. Have you had any operations? ☐No ☐Yes, What kind?_____
6. Do you use cigarettes/tobacco? ☐No ☐Yes, For how long? _____
7. Who is your Primary Care Physician?_____ Last visit?_____

FAMILY HISTORY

Please check if your Blood relatives have any of the following:
How are they related to you? Please SPECIFY: _____

☐Glaucoma:	☐Maternal	☐Paternal	☐Retinal disease:	☐Maternal	☐Paternal
☐Diabetes:	☐Maternal	☐Paternal	☐Blindness:	☐Maternal	☐Paternal
☐Other:	☐Maternal	☐Paternal			

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