PATIENT HISTORY QUESTIONNNAIRE

Patient name: _____ Today's Date _____

Who referred you to our practice_____ _____
What is the reason for today's eye exam?
_____ _____
When was your most recent eye exam? _____

Eyes drops Right eye Left eye
_____ _____ _____
_____ _____ _____
_____ _____ _____

Other Medications: (pills, Insulin)
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies to any medications:
_____ _____ _____

Other Allergies: _____
_____ _____

Have you noticed:	YES	NO
Eye Pain	___	___
Discharge	___	___
Blurred Vision	___	___
Redness	___	___
Itching of Eyes	___	___

Have you had:		
Cataracts	___	___
Glaucoma	___	___
Uveitis	___	___
Retinal Disease	___	___
Trauma to eyes	___	___
Eye surgery	___	___

Has anyone in your Family had:			Who:
Cataracts	___	___	_____
Glaucoma	___	___	_____
Retinal Diseases	___	___	_____
Diabetes	___	___	_____
Corneal Problems	___	___	_____
Vision Loss	___	___	_____
Crossed Eyes	___	___	_____

Have you had:	YES	NO
Heart Diseases	____	____
High blood pressure	____	____
Heart Attack	____	____
Dry Mouth	____	____
Lung Disease	____	____
Diabetes	____	____
Stroke	____	____
Gastrointestinal	____	____
Arthritis	____	____
Thyroid	____	____
Kidney Disease	____	____
Blood Disorder	____	____
Cancer	____	____
Skin Rash	____	____

Other: _____ _____
Surgery: _____ _____
Do you, or did you smoke? _____
Packs per day _____
Do you, or did you drink? _____
Drinks per day _____
Are you pregnant? _____
Contact Lens History:
Do you wear Contact Lenses? _____
what Type? (Hard, Soft, Gas Permeable)
_____ _____
what brand? _____