PATIENT HISTORY QUESTIONNAIRE

Date_____
Patient name_____
Parent, Guardian, or Caregiver (if applicable):_____
E-mail_____
Occupation_____Employer_____
Date and location of last eye exam_____
Main reason for today's visit?_____
How did you hear about us?_____

Do you wear eyeglasses? No___ Yes___ How old are the eyeglasses?_____
Do you wear them for: Distance___ Reading___ Both___
Do you wear contact lenses? No___ Yes___ Type:_____
If no, have you ever worn contacts? No___ Yes___
Have you ever had any eye injury or eye operation? Please Describe (with dates):_____
_____

Have you been told you have cataracts? Y / N glaucoma? Y / N macular degeneration? Y / N

Do any relatives (mother/father/siblings) have eye problems? Please circle all that apply:
glaucoma macular degeneration lazy eye retinal detachment other:_____

Are you being treated for any medical conditions? Please circle all that apply:
diabetes high blood pressure heart disease depression anxiety
athritis high cholesterol thyroid disease

Other:_____

Please list (or a give copy of) all medications that you are currently taking including vitamins, herbs and over the counter drugs:_____
_____
_____

Are you allergic to any medications? Please list (or give a copy):_____
_____

Name of primary care physician:_____Last visit:_____