Patient History Questionnaire

Last Name _____ First Name _____ Date _____

Personal Eye Information

1. What is the reason for your visit?

2. When was your last eye exam? _____

3. Have you had any eye injuries? ☐ No ☐ Yes

   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 eyeglasses now? ☐ No ☐ Full time ☐ Part Time

6. Have contact lenses ever been prescribed for you? ☐ No ☐ Yes

   Do you wear contact lenses now? ☐ No ☐ Full time ☐ Part Time

   Type of contact lenses _____

7. Please check any eye problems you have or previously had:

☐ Crossed eyes	☐ Cataracts	☐ Floaters	☐ Eye infection
☐ Double vision	☐ Glaucoma	☐ Seeing flashes	☐ Loss of Vision
☐ Amblyopia (lazy eye)	☐ Macular degeneration	☐ Retinal detachment	☐ Other eye disease

Personal Health History

1. Do you have problems with any of the following?

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

2. Have you been diagnosed with any of the following?
   ☐ Diabetes When was it diagnosed? _____ ☐ Rheumatoid arthritis ☐ Stroke
3. Are you allergic to any medications? ☐ No ☐ Yes Which ones?: _____
   _____
4. Are you taking 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. Name and city of your primary care doctor _____

Family History

1. Please check if your blood relatives have any of the following:

	Relationship to you:		Relationship to you:
☐ Glaucoma	_____	☐ Diabetes	_____
☐ Retinal disease	_____	☐ Blindness	_____
☐ Other eye disease	_____		