PATIENT HISTORY QUESTIONNAIRE

Patient Name:____ DOB: _________________________
Date: ___________________Sex: □ M □ F Phone: (____) _____________ SSN: ________________
Email: _________________________ Emergency Contact: ______________________ (____)__________

Are you coming in for a contact lens prescription? □ Yes □ No Date of last eye exam: _____________

MEDICAL INFORMATION

What is your general health? □ Poor □ Fair □ Good □ Excellent
Do you have problems with any of these systems? (Check all that apply)
□ Gastrointestinal □ Nervous □ Eyes
□ Respiratory □ Ears/Nose/Throat □ Genitourinary
□ Mental □ Integumentary (Skin) □ Cardiovascular
□ Musculoskeletal □ Endocrine □ Blood/Lymph □ Allergies/Immunologic
Explain:____

Check all that apply	Y	N	Explain
Medication Allergy			
Allergies			
Diabetes			
High Blood Pressure			
Headaches			
Elevated Cholesterol			
Alcohol Use			
Tobacco Use			

Please list all medications used ____

PLEASE SEE OTHER SIDE FOR MORE

Family Doctor: ________________________________Approximate Date of Last Visit:____________

Family History

Check all that apply	Y	N	Who in your family has had the following?
High Blood Pressure			
Diabetes			
Cancer			
Macular Degeneration			
Glaucoma			
Retinal Detachment			
Other Eye Conditions			**Type:**

Personal Eye Information

Check all that apply	Y	N	Explain (include type & date if applicable)
Eye Operations			
Eye Injury			
Dry Eyes			
Blurred Vision			
Flashes			
Floaters			
Halos			
Double Vision			
Other Eye Problems			
Glasses			
Contacts			Brand: Solution: How many days a week do you wear your contacts? ________ Hours per day? _______ Do you sleep in your lenses? Yes/No How often? __________Do you nap in your contacts? Yes/No How often? __________