Patient Information and Medical History Questionnaire

Date_____

Name _____ Responsible Party_____
Last First M.I. (If under 18 years of age)

Address _____ City _____ State _____ Zip_____

Phone (H)_____ (W) _____ (C) _____ E-mail _____

Birth date _____ Age_____ ❑ Male ❑ Female Social Security # _____

Occupation _____ Employer _____

Insurance Company_____

How were you referred to our office? ❑ Previous Patient ❑ Drive by ❑ Advertising ❑ Website ❑ Doctor Referral

❑ Yellow Pages ❑ Other_____ ❑ A Satisfied Patient _____ (Who may we thank?)

Ocular History

Date of last eye exam _____

Check any of the following which may apply:

❑ Crossed eyes	❑ Retinal Disease	❑ Double Vision	❑ Dryness	❑ Burning	❑ Sensitivity to Light
❑ Lazy eye	❑ Cataracts	❑ Floaters	❑ Redness	❑ Foreign Body	❑ Tired Eyes
❑ Drooping Eyelid	❑ Eye Infections	❑ Loss of Vision	❑ Mucous Discharge	❑ Excess Tearing	❑ Prominent Eyes
❑ Eye Injury	❑ Blurred vision	❑ Sandy/Gritty Feeling	❑ Eye Pain	❑ Glaucoma	❑ Flashes of Light
❑ Halos	❑ Itching	❑ Stye/Chalazion			

Do you wear glasses? ❑ No ❑ Yes If yes, how old is your present pair of lenses?_____

Does glare from oncoming headlights or your computer bother you? ❑ No ❑ Yes

Do you wear contact lenses? ❑ No ❑ Yes If yes, how old is your present pair of lenses? _____

Type of Contact lenses: ❑ Rigid Gas Permeable ❑ Soft ❑ Soft Disposable I replace every _____ ❑ Other

Are they comfortable: ❑ No ❑ Yes

Family History

Please check any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

Disease/Condition	Relationship to you	Disease/Condition	Relationship to you
❑ Blindness	_____	❑ Cataract	_____
❑ Crossed Eyes	_____	❑ Glaucoma	_____
❑ Macular Degeneration	_____	❑ Retinal Detachment/ Disease	_____
❑ Arthritis	_____	❑ Cancer	_____
❑ Diabetes	_____	❑ Heart Disease	_____
❑ High Blood Pressure	_____	❑ Kidney Disease	_____
❑ Lupus	_____	❑ Thyroid Disease	_____