PATIENT INFORMATION QUESTIONNAIRE

Date_____________ DOB _________________ Age _________ Preferred Name____________________
Last Name________________________ First Name____________________________ Middle Initial _________
Street Address _______________________________City_____________________State______Zip__________
Home Phone _________________Cell Phone ________________ Preferred Method of Contact: Home or Cell
Work Phone _____________________________ Email Address____
Social Security (Last 4)___________________ Occupation ____

Emergency Contact _______________________ Contact Phone ________________ Relationship ___________

MEDICAL INFORMATION

What is your general health?____
Do you have problems with any of these systems? (Please circle all that apply) Eyes Y/N

Gastrointestinal	Y/N	Nervous	Y/N	Mental	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine (glands)	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/Lymph	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Allergic/Immunologic	Y/N

Please explain____
Please answer all that apply:
Diabetes Y/N Type______________________________Date of diagnosis___________________
Allergies Y/N Allergy to what? _____________________What happens? ___________________
Medication allergy Y/N What happens? ____
Other Health Problems____
Current Medication(s)____
Have you had any operations? Y/N Kind? ________________________When___________________
Do you use cigarettes/tobacco? Y/N Alcohol? Y/N Other substance(s)_____________________

Family doctor_________________________ Phone Number ________________ Date of Last Visit __________

FAMILY HISTORY

High blood pressure Y/N Relation________________Macular degeneration Y/N Relation__________________
Diabetes Y/N Relation___________________________Retinal detachment Y/N Relation__________________
Glaucoma Y/N Relation__________________________ Cataracts Y/N Relation__________________
Other eye condition(s) Y/N What Kind?________________________________ Relation___________________

PERSONAL EYE INFORMATION

Date of last eye exam? Month__________________________ Year_____________________
Have you had any eye operations? Y/N _____________________________ Date_____________________
Have you had an eye injury? Y/N _____________________________ Date_____________________
Do you have Dry eyes? Y/N Glaucoma? Y/N Cataracts? Y/N Blurred Vision Y/N
Do you wear glasses? Y/N Contact Lenses? Y/N Type___________________________________
Additional information____

Whom may we thank for referring you? ____

Signature: ____

Revised 03/30/2015