PATIENT HISTORY QUESTIONNAIRE

DATE _____ Last Name _____
First Name _____ MI__ ____

Do you take medications for any of these systems? (**Please circle yes or no.**)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine	Yes/No
Ears/Nose/ Throat	Yes/No	Urinary	Yes/ No	Blood/ Lymph	Yes/No
Cardiovascular/Cholesterol	Yes/No	Muscles	Yes/No	Respiratory	Yes/No
Skin	Yes/No	Headaches	Yes/No	High Blood Pressure	Yes/No
Diabetes	Yes/No	Date of Diagnosis_____			

Do you have allergies to medications? Yes/No Which_____
Other health problems _____
Current Medications:_____
_____

FAMILY HISTORY

High Blood Pressure	Yes/No	Macular Degeneration	Yes/No	Glaucoma	Yes/No
Diabetes	Yes/No	Lazy Eye	Yes/No	Cataracts	Yes/No

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems?	Yes/No	What kind?_____	
Have you had any eye operations?	Yes/No	Type?_____	
Have you had any eye injuries?	Yes/No	What kind?_____	
Do you have glaucoma?	Yes/No		
Cataracts?	Yes/No		
Blurred Vision?	Yes/No	Do you wear glasses?	Yes/No
		Contact Lenses? Yes/ No	Type_____

DOCTOR USE ONLY

Reviewed by_____ Changes? Yes/No Date_____
Reviewed by_____ Changes? Yes/No Date_____
Reviewed by_____ Changes? Yes/No Date_____