

Name: \_\_\_\_\_

Chart: \_\_\_\_\_

Date: \_\_\_\_\_

**PATIENT HISTORY QUESTIONNAIRE**

Patient name \_\_\_\_\_

Today's Date \_\_\_\_\_

Who referred you to our practice \_\_\_\_\_

What is the reason for today's eye exam? \_\_\_\_\_

When was your most recent eye exam? \_\_\_\_\_

Do you currently wear prescription glasses? \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, do you need a stronger prescription? \_\_\_\_\_ YES \_\_\_\_\_ NO

How old are your glasses? \_\_\_\_\_

What do you use your glasses for (i.e. work, computer reading, activities)? \_\_\_\_\_

Would you be interested in a new pair of glasses? \_\_\_\_\_

Eyes drops Right eye Left eye

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Medications: (pills, Insulin)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies to any medications:

\_\_\_\_\_

Other Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

Has anyone in your

Family had: \_\_\_\_\_ Who: \_\_\_\_\_

Cataracts \_\_\_\_\_

Glaucoma \_\_\_\_\_

Retinal Diseases \_\_\_\_\_

Diabetes \_\_\_\_\_

Corneal Problems \_\_\_\_\_

Vision Loss \_\_\_\_\_

Crossed Eyes \_\_\_\_\_

Have you had: YES NO

Heart Diseases \_\_\_\_\_

High blood pressure \_\_\_\_\_

Heart Attack \_\_\_\_\_

Dry Mouth \_\_\_\_\_

Lung Disease \_\_\_\_\_

Diabetes \_\_\_\_\_

Stroke \_\_\_\_\_

Gastrointestinal \_\_\_\_\_

Arthritis \_\_\_\_\_

Thyroid \_\_\_\_\_

Kidney Disease \_\_\_\_\_

Blood Disorder \_\_\_\_\_

Cancer \_\_\_\_\_

Skin Rash \_\_\_\_\_

Other: \_\_\_\_\_

Surgery: \_\_\_\_\_

Do you, or did you smoke? \_\_\_\_\_

Packs per day \_\_\_\_\_

Do you, or did you drink? \_\_\_\_\_

Drinks per day \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

Contact Lens History: \_\_\_\_\_

Do you wear contact Lenses? \_\_\_\_\_

What Type? (Hard, Soft, Gas Permeable) \_\_\_\_\_

What brand? \_\_\_\_\_