

RETURNING *Patient History Questionnaire*



Please fill in any information that has changed:

Name: _____ Date: _____
(First) (M.I.) (Last)

Address: _____ City: _____ State: _____ Zip: _____

Phone (h): (_____) _____ Phone (w): (_____) _____ Phone (c): (_____) _____

Employer/Occupation: _____

E-mail: _____ Please check if you do NOT wish to receive eye care updates

Payment is due at the time of service. Payment will be made via: cash check credit card
 insurance _____
(Type)

PATIENT MEDICAL INFORMATION

Please list any changes to your medical history since your last exam.

Are you currently taking medication? y n Please list: _____

Are you allergic to medication? y n Please list: _____

FAMILY EYE & MEDICAL HISTORY

Please check (✓) any conditions that have occurred or changed in your immediate family:

- | | | | |
|---|----------------|--|----------------|
| <input type="checkbox"/> glaucoma | relation _____ | <input type="checkbox"/> cataracts | relation _____ |
| <input type="checkbox"/> macular degeneration | relation _____ | <input type="checkbox"/> diabetes | relation _____ |
| <input type="checkbox"/> retinal detachment | relation _____ | <input type="checkbox"/> high blood pressure | relation _____ |

PATIENT'S EYE HISTORY

Do you wear any type of glasses? y n Do you wear contact lenses? y n

Are you planning to get new glasses today? y n maybe, depending on the exam

Are you interested in wearing contact lenses? y n maybe, depending on the exam

Check all that apply: itchy eyes stinging/burning red eyes eye strain/eye fatigue blurry vision flashes/floaters

Are you using any eye drops (prescription or over-the-counter)? Please list: _____

Please describe any problems with your eyes for which you are seeking treatment today: _____

Is there any physician you would like to have today's exam results sent to? _____
(Name)