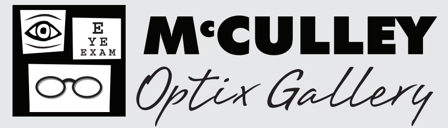
RETURNING PATIENT HISTORY QUESTIONNAIRE



(Circle) Dr. Mr. Mrs. Ms. Miss.

Date of Birth: ___ / ___ / ___ Age: ______

Name: ______________________________ Preferred Name: ______________________
(First) (M.I) (Last)

Address: ____

City: ______________________________ State: __________ Zip: ____________

Primary Phone: ____________________ Cell: ☐ Y ☐ N Email: ____________________

Employer/Occupation: ____

Payment is due at the time of service. Payment will be made via: ☐ Cash/Check ☐ Credit Card ☐ Insurance V M (Internal use)

PATIENT'S EYE HISTORY

Presenting Concerns Today: ____

____

Do you wear glasses? ☐ Y ☐ N Do you wear contact lenses? ☐ Y ☐ N ☐ soft/disposable ☐ hard/rigid gas permeable

Are you interested in wearing contact lenses? ☐ Y ☐ N ☐ Possibly, tell me more

Are you planning to get new glasses today? ☐ Y ☐ N ☐ Maybe, depending on the exam

Check all that apply:

☐ Blurry vision	☐ Eye strain/fatigue	☐ Itchy eyes	☐ Red eyes	☐ Dry eyes
☐ Stinging/burning	☐ Watery eyes	☐ Flashes of light	☐ Floaters	☐ Eye Twitch

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

PATIENT MEDICAL INFORMATION

Do you currently, or have you had, any problems in the following areas? (✓) all that apply.

☐ Cardiovascular/Heart Disease	☐ Cancer	☐ Headache
☐ Respiratory	☐ Endocrine/Glands	☐ Nervous System
☐ Blood/Lymph	☐ Thyroid	☐ Psychiatric/Physiological
☐ High Blood Pressure	☐ Gastrointestinal	☐ Muscles/Bones
☐ High Cholesterol	☐ Urinary Tract	☐ Integument/Skin
☐ Diabetes (date of diagnosis: _______)	☐ Ears/Nose/Throat	☐ Allergic/Immunologic

Please explain: ____

Other health problems: ____

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 in your immediate family:

☐ No eye diseases in my family history

☐ Glaucoma	Relation: __________	☐ Retinal Detachment	Relation: __________
☐ Macular Degeneration	Relation: __________	☐ Diabetes	Relation: __________
☐ Cataracts	Relation: __________	☐ High Blood Pressure	Relation: __________

Other family eye or medical history: ____

Is there any physician you would like to have today's exam results sent to? ____________________