Patient History Questionnaire

Date: _____

Name: _____ Birthdate: _____

Email address: _____ Pronouns: _____

Occupation: _____

Do you have health problems in any of these areas? Please circle all that apply.

Gastrointestinal	Y/N	Nervous System	Y/N	Mental Health	Y/N
Ear/Nose/Throat	Y/N	Urinary	Y/N	Thyroid/Endocrine	Y/N
Cardiovascular	Y/N	Muscle/Bones	Y/N	Blood/Lymph	Y/N
Respiratory	Y/N	Skin	Y/N	Allergies	Y/N

Please explain any "Y" responses from above:

_____

_____

Please answer all that apply below:

Diabetes Y/N Year of diagnosis: _____ High Blood Pressure Y/N Year of diagnosis: _____

Medication Allergies: _____

_____

Current Medications taken:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any surgeries? Y/N If yes, list here: _____

_____

Do you use tobacco? Y/N If yes, type and frequency: _____

FAMILY HISTORY

Diabetes Y/N Relation: _____ Macular Degeneration Y/N Relation: _____

Glaucoma Y/N Relation: _____ Retinal Detachment Y/N Relation: _____

Lazy Eye Y/N Relation: _____ Other Eye Conditions? _____

PERSONAL OCULAR HISTORY

Have you had any eye operations? Type and year: _____

Have you had any eye injuries? Type and year: _____

Glaucoma Y/N Cataracts Y/N Dry Eyes Y/N Macular Degeneration Y/N

Other eye conditions Y/N Explain: _____

Do you wear contact lenses? Y/N Brand/power (if known): _____

Name of primary care physician: _____

Name(s) of specialist(s) you see, if applicable: _____