

Love & Warden Eye Care

PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: THIS QUESTIONNAIRE IS TO BE REVIEWED AT EACH EXAM. PLEASE ANSWER ALL QUESTIONS.

(PLEASE PRINT)

Last Name _____ First Name _____ MI _____
Preferred First Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Work Phone _____ Home Phone _____ Cell Phone _____
Occupation _____ Employer _____ If Student, School _____
SSN _____ Referred by _____
Person responsible for account _____ Relationship to patient _____
Address (if different from patient) _____ City _____ State _____
Zip _____ Employer _____ Phone _____ Work Phone _____
Date of Last Eye Exam _____ Dilated? Yes / No Name of Doctor _____

MEDICAL INFORMATION

How is your general health? EXCELLENT GOOD FAIR POOR

Do you smoke Y / N Have you ever smoked? Y / N How long? _____

Do you have problems with any of these systems? (Please circle yes or no.)

Gastrointestinal Y / N Nervous Y / N Endocrine (glands) Y / N

Ears/Nose/Throat Y / N Urinary Y / N Blood/Lymph Y / N

Cardiovascular Y / N Muscles/Bones Y / N Allergic/Immunologic Y / N

Respiratory Y / N Skin Y / N Headaches Y / N

High Blood Pressure Y / N Mental Y / N Are you pregnant? Y / N

Please Explain _____

Diabetes Y / N Type _____ Date of Diagnosis _____

Allergies to Medication Y / N Which? _____ Reactions _____

Other Health Problems _____

Current Medication(s) _____

Have you had any operations? Y / N Kind? _____ When? _____

Name of family doctor _____ Date of last visit _____

FAMILY HISTORY

High Blood Pressure Y / N Relation _____ Macular Degeneration Y / N Relation _____

Diabetes Y / N Relation _____ Retinal Detachment Y / N Relation _____

Glaucoma Y / N Relation _____ Lazy Eye Y / N Relation _____

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? Y / N What kind? _____

Have you had any eye operations? Y / N Type _____ Date _____

Have you had any eye injuries? Y / N Kind _____ Date _____

Do you have glaucoma? Y / N Cataracts Y / N Dry Eyes Y / N

Macular degeneration Y / N Retinal detachment Y / N Blurred vision Y / N

Lazy eye Y / N Itchy/Watery Eyes Y / N Double vision Y / N

Do you wear glasses Y / N Contacts Y / N Type _____ Brand _____

Time spent on a computer per day _____ Hobbies/Sports/Interests _____

Vision Insurance _____ Medical Insurance _____

DOCTOR USE ONLY

Reviewed by _____ No Changes _____ Date _____

Reviewed by _____ No Changes _____ Date _____

Reviewed by _____ No Changes _____ Date _____