LOVE & WARDEN

PATIENT HISTORY QUESTIONNAIRE

Date ___________

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

(PLEASE PRINT)

Last Name ______________________________ First Name ______________________________ MI _______Gender M / F _______

Preferred First Name ____Date of Birth ____________________________________

Address _________________________________City ______________________________ State __________ Zip ______________

Work Phone _________________________ Home Phone _________________________ Cell Phone __________________________

Occupation _________________________ Employer _________________________ If Student, School _________________________

SSN _________________________ Referred by _________________________ Email ___________________________________

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 ____________