PATIENT HISTORY QUESTIONNAIRE

(Must be updated at each visit)

Patient Name: _____ Date: _____

MEDICAL INFORMATION
SYSTEMS REVIEW

Do you have problems with any of the following systems?

	Yes	No		Yes	No		Yes	No
Eyes	☐	☐	Gastrointestinal	☐	☐	Nervous	☐	☐
Ears/Nose/Throat	☐	☐	Genitourinary	☐	☐	Endocrine (glands)	☐	☐
Cardiovascular	☐	☐	Musculoskeletal	☐	☐	Blood/Lymph	☐	☐
Respiratory	☐	☐	Integumentary (Skin)	☐	☐	Allergic/Immunologic	☐	☐
						Mental	☐	☐

Please Explain: _____

SOCIAL HISTORY

	Yes	No		Yes	No		Yes	No
Do you use cigarettes/tobacco?	☐	☐	Alcohol?	☐	☐	Other Substances?	☐	☐

PERSONAL EYE INFORMATION

	Yes	No	
Have you had any eye operations?	☐	☐	Type: _____ Date: _____
Have you had an eye injury?	☐	☐	What kind? _____ Date: _____
Do you wear glasses?	☐	☐	How long have you had your current pair? _____
Do you wear contact lenses?	☐	☐	What kind? _____

	Yes	No
Do you have cataracts?	☐	☐
Do you have glaucoma?	☐	☐
Do you have blurred vision?	☐	☐
Do you have dry eyes?	☐	☐
Other eye problems?	☐	☐
Are you considering LASIK?	☐	☐

Patient Signature: _____ **Date:** _____