VISION ASSOCIATES
OPTOMETRISTS/OPTICIANS

PATIENT HISTORY QUESTIONNAIRE
(PLEASE UPDATE AT EACH VISIT)

Last Name _____ First Name _____

Address _____ Emergency Contact Name _____

City, State, Zip _____ Phone (_____) _____

Phone (_____) _____ Date of Last Eye Exam _____

Email Address _____ Referred By _____

Date of Birth _____ Primary Vision Coverage _____

Occupation _____ Secondary Coverage _____

Employer _____

MEDICAL INFORMATION

How is your general health?

Do you take medications for any of these systems? (Please check Yes or No boxes)

Gastrointestinal	☐ Yes ☐ No	Nervous	☐ Yes ☐ No	Endocrine	☐ Yes ☐No
Ears/Nose Throat	☐ Yes ☐ No	Urinary	☐ Yes ☐No	Blood/Lymph	☐ Yes ☐No
Cardiovascular	☐ Yes ☐ No	Muscles/Bone	☐ Yes ☐No	Allergis/Immonologic	☐ Yes ☐No
Respiratory	☐ Yes ☐ No	Integumentary (skin)	☐ Yes ☐No	Headaches	☐ Yes ☐No
High Blood Pressure	☐ Yes ☐ No	Eyes	☐ Yes ☐No	Mental	☐ Yes ☐No

Please explain _____

Diabetes ☐ Yes ☐No _____ Type _____ Date of Diagnosis _____

Allergies to medication ☐ Yes ☐No Which? _____ Reactions? _____

Other health probelms _____

Current medications _____

_____

Have you had any operations? ☐ Yes ☐No Kind? _____ When? _____

Name of family doctor and/or primary care physician _____

Date of last visit _____ Date your blood pressure was last checked? _____

FAMILY HISTORY

Diabetes ☐ Yes ☐No Relation_____ Macular degeneration ☐ Yes ☐No Relation_____

Glaucoma ☐ Yes ☐No Relation_____ Retinal Detachment ☐ Yes ☐No Relation_____

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? ☐ Yes ☐No What kind _____

Have you had and eye operations? ☐ Yes ☐No Type _____ Date _____

Have you had any eye injury? ☐ Yes ☐No Kind _____ Date _____

Do you have glaucoma?	☐ Yes ☐No	Cataracts?	☐ Yes ☐No	Dry Eyes?	☐ Yes ☐No
Macular degeneration	☐ Yes ☐No	Retinal detachment?	☐ Yes ☐No	Blurred Vision	☐ Yes ☐No
Do you wear glasses?	☐ Yes ☐No	Contact lenses?	☐ Yes ☐No	Type	_____

Additional information _____

X _____ _____

Please sign here ***Date***