VISION ASSOCIATES
OPTOMETRISTS/OPTICIANS

PATIENT HISTORY QUESTIONNAIRE

(PLEASE UPDATE AT EACH VISIT)

Last Name_____ First Name_____
Address_____ Apt_____ City_____ State___ Zip_____
Telephone (H) _____(Cell)_____(W)_____
SSN_____-_____-_____ Date of Birth_____
Occupation_____ Employer_____
Emergency Contact/Telephone No._____
Date of Last Eye Exam_____

MEDICAL INFORMATION

Do you have problems with any of these systems? *(please circle all that apply)*

Stomach/G.I.	Y/N	Nervous System	Y/N	Blood/Lymph	Y/N
Ears/Nose/Throat	Y/N	Muscle/Bone	Y/N	Mental Health	Y/N
Cardiovascular	Y/N	Skin	Y/N		
Respiratory	Y/N	Endocrine (glands)	Y/N		

Please Explain_____
_____

PLEASE ANSWER ALL THAT APPLY:

Diabetes Y/N Type I or II? Date of Diagnosis_____
High blood pressure Y/N Date of Diagnosis_____
Allergies Y/N Allergic to what?_____ What happens?_____
Medication Allergy Y/N What happens?_____
Headaches Y/N Location/Frequency_____
Current Medication(s)_____
Have you had any operations? Y/N Kind?_____ When?_____
Name of primary care doctor_____ Date of last visit_____

FAMILY HISTORY

High Blood Pressure Y/N Relation_____ Diabetes Y/N Relation_____
Cataracts Y/N Relation_____ Macular Degeneration Y/N Relation_____
Glaucoma Y/N Relation_____ Retinal Detachment Y/N Relation_____
Other eye condition(s) Y/N What kind?_____ Relation_____

PERSONAL EYE INFORMATION

Have you had any eye injuries? Y/N Kind_____ Date_____
Have you had any eye operations? Y/N Type_____ Date_____
Do you have Glaucoma Y/N Cataracts Y/N Dry eyes Y/N Blurred vision Y/N
Other eye problems Y/N Please describe_____
Do you wear glasses Y/N Contact Lenses Y/N Kind/Brand_____
Are you interested in Laser Vision Correction Y/N
Whom may we thank for referring you?_____

X_____ _____
Please sign here ***Date***