Patient Information/ Medical History Questionnare Date_____________

Name _______________________________ Birth Date ____________ ☐ M ☐ F Occupation_________________
Address _________________________________ City ____________________ State _____ Zip Code___________
Phone ( )________________ Cell/Work Phone ( )________________ Email __________________________
☐Married ☐Single ☐Widowed ☐Divorced Hobbies: ____

Do you now, or have you ever had, a history/surgery of the following:

If you check YES, please circle/describe the condition.

CURRENT / PAST MEDICAL HISTORY	Yes	No	Describe here
Significant Weight Loss, COVID-19			
Ears, Nose, Mouth, Throat, Allergies			
Heart, High Blood Pressure, stroke (Cardiovascular)			
Asthma, emphysema, Tuberculosis (Respiratory)			
Bladder, STD, kidney, prostate (Genitourinary)			
Arthritis, osteoporosis (Musculoskeletal)			
Skin disease/disorder- Psoriasis, Eczema(Integument)			
Epilepsy, Seizures, Headaches/Migraine (Neurologic)			
Depression, anxiety, dementia (Psychiatric)			
Diabetes, Thyroid, Hypoglycemia (Endocrine Disor)			
Anemia, High cholesterol, Liver Dis (Blood/Lymph)			
Lupus, HIV, Herpes, Multiple scleros (Immunologic)			
Irritable bowel, Crohn’s Ds, colitis, ulcers (Digestive)			
Cancer/Currently Pregnant/other medical problems			

SIGNIFICANT IMMEDIATE FAMILY HISTORY	Yes	No	If yes, state who
Diabetes			
High Blood Pressure/Stroke/Heart problems			
Glaucoma, Blindness			
Retinal Disease, Macular Degeneration			
Cancer			
Autoimmune Ds, Other			

EYE HISTORY	Yes	No	If yes, please describe
Injuries, Prosthesis			
Surgery, Laser treatment			
Lazy Eye (Amblyopia, Exotropia, Esotropia)			
Double Vision (prism)			
Corneal (Dry eye, scar, Keratoconus, Fuch’s)			
Cataracts			
Glaucoma, High Intraocular Pressure			
Retinal Disease, Vitreous/Floaters			
Macular Degeneration, Drusen			
Loss of vision- temporary or sudden			

Current Medications:

Current Eye Drops:

Allergic to any Medications? Incl reaction:

SOCIAL HISTORY	Y	N
Tobacco		
Alcohol		
Recreational drugs		

Last Eye Exam ____________
Dr.__________________
Eye(s) Dilated ☐Y ☐N
Primary Care Physician:
Dr.____________________

Insurance Information

Insurance______________________ Patient’s ID#______________________ Group#__________________
Phone #________________________ Insured Name______________________ Ins. Birth Date _____________
Insured: ☐Full time ☐Part time ☐Retired Relationship to Insured: ☐Self ☐Spouse ☐Dependent

Thank you!

Rev 4/2021