Patient Information and Medical History Questionnaire Date _____

Name _____ Date of Birth _____ Social Security # _____
Last First M.I.

Address _____ City _____ State_____ Zip _____

Phone Numbers _____ Email _____ ☐ Male ☐ Female

Responsible Party _____
(if under 18 years of age) Name Date of Birth Social Security #

Occupation _____ Employer _____

Reason for Visit / Chief Complaint_____

Ocular History

Check any of the following which may apply: Date of last eye exam _____

☐ Blurred Vision Distance	☐ Lazy Eye	☐ Cataracts	☐ Eye Pain	☐ Dryness	☐ Sensitivity to Light
☐ Blurred Vision Near	☐ Eye Injury	☐ Glaucoma	☐ Itching/Burning	☐ Redness	☐ Flashes of Light
☐ Crossed Eyes	☐ Retinal Disease	☐ Double Vision	☐ Floaters	☐ Eye Surgery	☐ Other _____

Do you wear glasses? ☐ No ☐ Yes Contact lenses? ☐ No ☐ Yes If no, **would** you like to try the? ☐ Yes ☐ No

Type of Contact Lenses? ☐ RGP ☐ Soft Are your contacts comfortable? ☐ No ☐ Yes

Replacement Schedule: ☐ 1 Day ☐ Two Weeks ☐ One Month ☐ Other_____ Do you sleep in your contact lenses? ☐ No ☐Yes

Please list a few of your hobbies _____

Medical History

List any medications you take (prescription, over-the-counter) _____

_____

Drug Allergies? ☐ No ☐ Yes If yes, list _____

Are you currently pregnant and/or nursing? ☐ No ☐ Yes

Personal History

Do you currently, or have you ever had any problems in the following areas?

☐ Diabetes	☐ High Blood Pressure	☐ Migraines	☐ Allergies/Hay Fever	☐ Rheumatoid Arthritis
☐ Heart Disease	☐ Headaches	☐ Thyroid	☐ Asthma	☐ Other _____

Family History

Please check any family history (parents, siblings, children, grandparents) for the following conditions:
□ Macular Degeneration □ Diabetes □ Glaucoma □ Cataract □ Other Ocular Disease _____

Social History

☐ I would prefer to discuss my social history information directly with my doctor.

Do you use tobacco products? ☐ No ☐ Yes Do you drink alcohol? ☐ No ☐ Yes

Race/Ethnicity

☐ American Indian or Alaska Native
☐ Black or African American
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Native Hawaiian/Other Pacific Islander
☐ White
☐ Other

I have filled out this form to the best of my ability

_____ _____
Signature Date