Patient History Questionnaire

Date:_____ ***Preferred Pharmacy:** _____

Last Name: _____ **First:**_____ **Middle initial:**_____**Nickname:**_____

Date of Birth:_____ Gender:_____ Last 4 of SSN :_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone/Home:_____ **Cell:**_____ **Work:**_____

Email:_____

Occupation:_____ **Referred By**:_____

Family Doctor:_____ Last Physical/Medical Exam:_____

Responsible Party

Name of person responsible for this account_____ Relationship to patient_____

Phone: _____

Medical History

Please circle if you have the following: **Diabetes:** No / Yes___If Yes: Type_____ **High Blood Pressure:** No / Yes

High Cholesterol: No / Yes **Heart Disease:** No / Yes **HIV Positive:** No / Yes **Thyroid Disease:** No / Yes: **HYPER / HYPO**

Other:_____

List Medications that you currently take (including over the counter supplements and vitamins) (provide list if needed)

_____

****ALLERGIES TO MEDICATIONS:*** No / Yes:_____

Are you pregnant (if applicable)? No / Yes **Nursing?** No / Yes

Emergency Contact:_____Relationship:_____Phone: _____

Ocular History

Do you have or have you had the following (please circle all that apply):

Cataracts | Diabetic Retinopathy | Dry Eyes | Eye injury | Glaucoma | Macular Degeneration | Other:_____

Do you wear eye glasses? No / Yes: How old are your current glasses?_____

***Do you wear contacts?** No / Yes: **circle: soft lenses or hard lenses** **Are you interested in Contacts? Y/ N**

Ocular Surgeries: _____

Last Eye Exam:_____ Location:_____

Family History (If yes, Please note parent, grandparent, sibling, children)

Cataract: No / Yes_____ Retinal Disease/Detachment: No / Yes_____

Glaucoma: No / Yes_____ Diabetes: No / Yes_____

Macular Degeneration: No / Yes_____ High Blood Pressure: No / Yes_____