Precision Vision Optometry

Patient History Questionnaire

Today's Date_____

Last Name_____ First Name_____MI_____

Date of Birth _____ SSN _____-_____-_____ Gender: M F _____

Address_____ City_____State_____Zip_____

Cell Phone_____ Home Phone_____ E-Mail _____

Employer (or School) _____ Occupation (or Grade)_____

Emergency Contact _____ Relationship_____Phone Number _____

Referred by _____ Preferred Language_____

Patient Medical Information

Do you have problems with any of these systems? If Yes, please check box.

- ☐ Allergic/Immunologic
- ☐ Blood/Lymph
- ☐ Cardiovascular/Heart disease
- ☐ Ears/Nose/Throat
- ☐ Endocrine (glands)
- ☐ Gastrointestinal
- ☐ Genitourinary
- ☐ Integumentary/Skin
- ☐ Muscles/Bones
- ☐ Neurological
- ☐ Psychiatric
- ☐ Respiratory
- ☐ Other (Please Specify):_____
- ☐ None

Do you have?

High blood pressure Yes / No

Elevated cholesterol Yes / No

Diabetes Yes / No Type: I / II Year Diagnosed_____

Do you use?

Cigarettes/tobacco Yes / No / In the Past

Other substance(s) _____

Current medication(s) _____

Current eye drop(s) _____

Allergies to medication(s) or other substance(s) Yes/No Which?_____ Reactions? _____

Have you had any operations? Yes / No Type? _____ When? _____

Are you pregnant and / or nursing? Yes / No

Name of primary care physician _____

Last physical exam_____ Last blood work _____

Patient Eye Information

Last eye exam _____ Eyes have been dilated? Yes / No Year:_____

Do you have any of the following? If Yes, please check box

- ☐ Amblyopia
- ☐ Cataracts
- ☐ Dry eyes
- ☐ Floater/ Flashes
- ☐ Glaucoma
- ☐ Other eye problems (Please Specify): _____
- ☐ Itchy eyes
- ☐ Macular degeneration
- ☐ Retinal detachment
- ☐ Strabismus
- ☐ None

Eye operation? Yes/ No Type _____Date _____

Eye Injury? Yes/ No Type _____Date _____

Glasses? Yes/ No How old is your present pair of lenses? _____

Contacts? Yes/ No Type/Brand: _____

Family History

Do your family have any of the following? If Yes, please check box

- ☐ Cataracts Relation_____
- ☐ Diabetes Relation_____
- ☐ Glaucoma Relation_____
- ☐ High blood pressure Relation_____
- ☐ Macular degeneration Relation_____
- ☐ Retinal detachment Relation_____

Please complete the second page on the back