Patquest 2007-word

PATIENT HISTORY QUESTIONNAIRE

(Must be updated at each visit)

Please circle one: Dr. Mr. Mrs. Ms. SS# (of patient)_________- _________ - ___________

First Name _________________________________ MI_______ Last Name ___________________________________

Address __________________________________ City ______________________ State ______ Zip _______________

Home Phone (___) _____ - _________Work Phone (____) _____ - _______X ______Cell (_____) _____ - ___________

Date of Birth ___/___/______ Date of Last Exam ___/___/___ Were you dilated? Yes No

E-Mail Address____

Occupation ______________________________ Employer ____

Name of Vision Insurance: VSP DAVIS EYEMED MEDICARE Other____________________________

Name (of insured)_______________________ SS # (of insured) _____-_____-______ Today's Date_______________

MEDICAL INFORMATION

How is your general health? ____

Do you have problems with any of these systems? (Please circle all that apply) Eyes Y/N

Gastrointestinal	Y/N	Nervous	Y/N	Mental	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine (glands)	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood / lymph	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Allergic / immunologic	Y/N

Please Explain ____

Please answer all that apply to you:

Diabetes Y/N Type ______________________________ Date of diagnosis _______________________

Allergies to any medications? Y/N Which Medications? _____________________ What Happens?_________________

Sinus/Seasonal Allergies? Y/N Headaches? Y/N High blood Pressure? Y/N High Cholesterol? Y/N

Other health problems ____

List all current medications____

Have you had any operations? Y/N Kind? ______________________________ When?________________________

Do you use cigarettes / tobacco? __________________ Alcohol? ______________Other substance (s)______________

Name of family doctor ____ Date of last visit ________________________

Date of last tetanus shot__________ Are you, or could you be pregnant Yes / No How many weeks? _____________

FAMILY HISTORY

Diabetes	Y/N Relation ___________________	Macular degeneration	Y/N Relation ______________
High Blood Pressure	Y/N Relation ___________________	Retinal detachment	Y/N Relation ______________
Glaucoma	Y/N Relation ___________________	Cataracts	Y/N Relation ______________

Other eye condition (s) Y/N What kind? ____ Relation _____________

PERSONAL EYE INFORMATION

Have you had any eye operations? Y/N Type ____________________________ Date _______________

Have you had an eye injury? Y/N Kind ____________________________ Date _______________

Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred vision? Y/N

Other eye problems? Y/N What kind?____

Do you wear glasses? Y/N Contact lenses? Y/N Type ____________________________

How often do you sleep in your contact lenses? ____Often ____Sometimes ____Never

Whom may we thank for referring you? _________________________________ Walk-in Postcard

INFORMATION UPDATE ONLY **Doctor's Review Initials:______**

1) Patient's initials_______	**2)** Patient's initials _______	**3)** Patient's initials ______	**4)** Patient's initials________
Doctor's initials _______	Doctor's initials _______	Doctor's initials _______	Doctor's initials________
Updated date _________	Updated date ________	Updated date ________	Updated date__________