VSP

PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last name _____ First name _____ MI _____

Address _____ City _____ State _____ Zip _____

Work phone (____)_____ Home phone (____)_____ SSN ___-___-____

DOB _____ Occupation _____ Employer _____

Emergency contact name _____ Phone number (____)_____

Date of last eye exam _____ Dilated? Yes/No

Today's date _____ Referred by _____

Medical Information

What is your general health? _____

Do you have problems with any of these systems? **(Please circle yes or no.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/lymph	Yes/No
Cardiovascular	Yes/No	Muscles/bones	Yes/No	Allergic/immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain _____

Diabetes Yes/No Type_____ Date of diagnosis _____

Allergies to medication? Yes/No Which? _____ Reactions? _____

Other health problems _____

Current medication(s) _____ Check if none ☐

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

Name of family doctor_____

Date of last visit _____ Date of last tetanus shot _____

Family History

High blood pressure	Yes/No	Relation _____	Macular degeneration	Yes/No	Relation _____
Diabetes	Yes/No	Relation _____	Retinal detachment	Yes/No	Relation _____
Glaucoma	Yes/No	Relation _____	Cataracts	Yes/No	Relation _____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? _____

Have you had any eye operations? Yes/No Type_____ Date _____

Have you had an eye injury? Yes/No Kind_____ Date _____

Do you have glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No

Macular degeneration? Yes/No Retinal detachment? Yes/No Blurred vision? Yes/No

Do you wear glasses? Yes/No Contact lenses? Yes/No Type _____

Additional information _____

Doctor Use Only

Reviewed by _____ ☐ No changes Date _____

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