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? Y/N 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___________