



Patient History Questionnaire

Name \_\_\_\_\_

Today's date \_\_\_\_\_

Past History

Date of last eye exam \_\_\_\_\_

List all major illnesses and injuries:

List any surgeries you have had:

List all medications you are currently taking:

Please list any medications you are allergic to:

Review of Systems

Do you have any problems in the following areas? If so, please explain.

Table with columns: System Category, YES, NO, Explanation of Problem. Rows include Constitutional Symptoms, Eyes, Allergic/Immunologic, Ears, nose, mouth, throat, Cardiac/Vascular, Respiratory, Gastrointestinal, Musculoskeletal, Integumentary, Neurological, Psychiatric, Endocrine, and Hematologic.

Family History

Table with columns: YES, NO, Condition, YES, NO. Rows include Blindness, Glaucoma, Diabetes, and Migraine Headaches.

Social History

Current Occupation \_\_\_\_\_

Table with columns: YES, NO, Question. Rows include Do you drink alcohol?, Do you smoke?, and Have you had a blood transfusion?.