



# The Eye Care Center

179 York Road

Warminster, PA 18974

(215) 674-20/20

## PATIENT HISTORY QUESTIONNAIRE

(must be updated at each visit)

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_

Telephone (Work) \_\_\_\_\_ (Home) \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of birth \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Emergency contact/Telephone no. \_\_\_\_\_

Date of last eye exam \_\_\_\_\_ Dilated? \_\_\_\_\_ Today's date \_\_\_\_\_

### MEDICAL INFORMATION

What is your general health? \_\_\_\_\_

Do you have problems with any of these systems? (please circle all that apply)

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

Please explain \_\_\_\_\_

Please answer all that apply:

Diabetes Y/N Type \_\_\_\_\_ Date of diagnosis \_\_\_\_\_

Allergies Y/N Allergic to what? \_\_\_\_\_ What happens? \_\_\_\_\_

Medication allergy Y/N What happens? \_\_\_\_\_ Headaches Y/N

Other health problems \_\_\_\_\_

Current medication(s) \_\_\_\_\_

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 \_\_\_\_\_

### FAMILY HISTORY

High blood pressure Y/N Relation \_\_\_\_\_ Macular degeneration Y/N Relation \_\_\_\_\_

Diabetes 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 any eye injuries? Y/N Type \_\_\_\_\_ 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 \_\_\_\_\_

Additional information \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Doctor's initials \_\_\_\_\_