DUBUQUE FAMILY Eye Care

Patient History Questionnaire

Patient Information

Last Name_____ First Name_____ MI_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Work_____ Cell_____
E-mail address_____ Gender: Male Female
Date of Birth_____ Occupation_____ Employer_____
Emergency Contact Name_____ Phone Number_____
Preferred Language _____ Race _____ Ethnicity: Hispanic/Latino Not Hispanic/Latino
Social Security Number_____-_____-_____
Date of Last Eye Exam_____ Dilated? Yes No Dominant Hand: Right Left
Vision Insurance_____ Medical Insurance_____

Guarantor/Responsible Party information - *Required* - □ Check box if same as patient

Guarantor Name_____ Relationship to patient_____
Birth Date_____ Social Security Number_____-_____-_____
Employer_____
Mailing address if other than that of patient_____

Medical Information

Current Medications_____
_____
Are you allergic to any medications? No__Yes__list_____
Do you have any problems with any of these systems? (Please circle all that apply)

Gastrointestinal	YES/NO	Neurological	YES/NO	Respiratory	YES/NO
Ears/Nose/Throat	YES/NO	Genitourinary	YES/NO	Mental	YES/NO
Cardiovascular	YES/NO	Musculoskeletal	YES/NO	Blood	YES/NO
Allergic/immunologic	YES/NO	Skin	YES/NO		

Please explain_____
Other health problems_____
Diabetes YES/NO Type_____ Date of diagnosis_____
Name of Family Doctor_____ Date of last visit_____
Do you use tobacco?____ alcohol?_____ Females: Are you currently pregnant? Yes_____ No_____

Past Eye History

Have you had any eye operations? YES/NO Type_____
Have you had an eye injury? YES/NO Kind_____
Do you have any of the following eye conditions?

Retinal detachment	YES/NO	Cataracts	YES/NO	Dry eyes	YES/NO
Macular degeneration	YES/NO	Glaucoma	YES/NO	Blurred vision	YES/NO

Do you have any other eye problems? YES/NO What kind?_____
Do you wear glasses? YES/NO Contact lenses? YES/NO Type_____

Family History (Children, Siblings, Parents)

High blood pressure YES/NO Relation_____ Macular degeneration YES/NO Relation_____
Diabetes YES/NO Relation_____ Glaucoma YES/NO Relation_____
Cancer YES/NO Relation_____ Cataracts YES/NO Relation_____
Hypothyroidism YES/NO Relation_____ Other eye conditions YES/NO Relation_____
Hyperthyroidism YES/NO Relation_____ If yes, please explain _____