

**Monte Vista Eye Care Center
Patient History Questionnaire**

Today's date _____
Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Home Telephone _____ Work Phone _____
SSN _____ Date of Birth _____
Occupation _____ Employer _____
Emergency Contact/Telephone# _____
Date of last eye exam _____ Dilated? Y/N _____

Medical Information

What is your general health? _____
Do you have problems with any of these systems?(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:

Diabetes? Y/N Type? _____ Date of Diagnosis _____
Allergies? Y/N To what? _____ What Happens? _____
Medications allergies? Y/N What happens? _____
Other health problems _____

Current medications _____
Have you had any surgeries? Y/N Kind? _____
Do you use tobacco products? _____ Alcohol? Y/N Other substances? Y/N
Name of family doctor? _____ Date of last visit? _____
Date of last tetanus shot? _____ Do you have a living will? Y/N

Family History

High blood pressure Y/N Relation _____ Macular degeneration Y/N Relation _____
Diabetes? Y/N Relation _____ Retinal detachment? Y/N _____
Glaucoma? Y/N Relation _____ Cataracts? Y/N Relation _____
Other eye conditions? Y/N What kind? _____ Relation _____

Personal Eye Information

Have you ever had any eye surgeries? Y/N Type _____ Date _____
Have you had any eye injuries? Y/N Kind _____
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 _____

Doctor's initials _____ Review _____