ST. LOUIS EYECARE

PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions. Date: _____

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____

Date of birth _____ Occupation _____ Employer _____

Emergency Contact Name _____ Phone Number _____

Date of Last Eye Exam _____ Dilated? Yes or No Referred by _____

Primary Vision Coverage _____ Secondary Vision Coverage _____

Medical Information

What is your general health? _____

Do you have problems with any of these systems? (Please check Yes or No)

Gastrointestinal	Y ◯ N ◯	Nervous	Y ◯ N ◯	Endocrine (glands)	Y ◯ N ◯
Ear/Nose/Throat	Y ◯ N ◯	Urinary	Y ◯ N ◯	Blood/Lymph	Y ◯ N ◯
Cardiovascular	Y ◯ N ◯	Muscles/Bones	Y ◯ N ◯	Allergic/Immunologic	Y ◯ N ◯
Respiratory	Y ◯ N ◯	Integumentary (skin)	Y ◯ N ◯	Headaches	Y ◯ N ◯
High Blood Pressure	Y ◯ N ◯	Eyes	Y ◯ N ◯	Mental	Y ◯ N ◯

Please explain _____

Diabetes Y ◯ N ◯ Type _____ Date of Diagnosis _____

Allergies to Medication Which?_____ Reactions? _____

Other health problems _____

Current medication(s) _____

Have you had any operations? Y ◯ N ◯ Kind? _____ When? _____

Date of last visit _____ Date of last tetanus shot _____

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_____

Personal Eye Information

Do you have any eye conditions or problems? Y ◯ N ◯ What kind? _____

Have you had any eye operations? Y ◯ N ◯ Type _____ Date _____

Have you had an eye injury? Y ◯ N ◯ Kind _____ Date _____

Do you have any of the following?

Glaucoma	Y ◯ N ◯	Cataracts	Y ◯ N ◯	Dry Eyes	Y ◯ N ◯
Macular Degeneration	Y ◯ N ◯	Retinal detachment	Y ◯ N ◯	Blurred Vision	Y ◯ N ◯
Do you wear glasses	Y ◯ N ◯	Contact Lenses	Y ◯ N ◯	Contact Type	_____

Additional Information _____

Doctor Use Only

Reviewed by _____ Date_____

Reviewed by _____ Date_____

Reviewed by _____ Date_____

Fill in, print and bring to the form to your appointment