Patient History Questionnaire

General Information

Name: Last, First, (MI) _____

Mailing Address _____

City _____

State, Zip _____

Telephone # _____

Cell # _____ Text Ok? _____

Date of Birth _____

SS# _____

Preferred Language _____

Race

- o American Indian
- o Asian
- o Black/ African American
- o Hispanic
- o Native Hawaiian/ Pacific Islander
- o White

Occupation _____

Employer _____

Emergency Contact & Telephone Number _____

_____

Date of last eye examination _____

Eyes Dilated? Y-N

Contact Information

Email Address _____

Whom can we thank for referring you?

_____

How would you like us to contact you?

_____

Personal Eye Information

Have you had any eye operations? Y-N

Type & Date _____

Do you have glaucoma? Y-N

Cataracts? Y-N

Dry Eyes? Y-N

Blurred Vision Y-N

Other eye problems? _____

Do you wear glasses? Y-N

Contact Lenses? Y-N

Family History

Diabetes Y-N Relation _____

Glaucoma Y-N Relation _____

Retinal Detachment Y-N

Medical Information

Do you have a problem with any of these systems? (Please circle all that apply)

Eyes	Musculoskeletal
Gastrointestinal	Blood/Lymph
Nervous	Respiratory
Mental	Integumentary (Skin)
Ear/Nose/Throat	Allergic _____
Endocrine (Glands)	Genitourinary
Cardiovascular	Other _____

Are you pregnant? Y-N

Diabetes/ Type Y-N

Date of Diagnosis _____

Current Medications _____

_____

Have you had any operations? Y-N

What Kind? _____

Cigarettes/tobacco?* Y-N

*If you use tobacco products Ephrata Eye Care is required by CMS to recommend pharmaceutical/psychological cessation therapy.

Alcohol? Y-N How Much? _____

Name of Family Doctor _____

Height _____ Blood Pressure _____

Weight _____ Pulse _____

I have received a copy of Ephrata Eye Care's privacy policy. Please sign below.

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