# Optical Expressions
## Patient History Questionnaire

Today's Date____/____/____

**Patient Information**

Last Name_____ First Name_____ MI_____
Address_____ City_____ State_____ Zip_____
Home#(____)_____ Wk#(____)_____ Cell(____)_____
DOB___/_____/_____ SS#_____-_____-_____
Occupation_____ Employer_____
Emergency Contact_____ Contact # (____)_____
How did you hear about us:_____
Date of last eye exam_____/_____/_____ Were you dilated? Yes / No
Email address_____
Race_____ Ethnicity_____
Referred by:_____

**Insurance Information**

Medical (health) Insurance_____
Vision Insurance_____
Main Insured_____ DOB Main Ins___/___/___ SS#_____-_____-_____

**Personal Medical Information**

Height ___'___ Weight _____lbs
What is your general health?_____
Do you have problems with these systems? (circle yes or no)

| | | | |
|---|---|---|---|
| Eyes | Yes / No | | |
| Gastrointestinal | Yes / No | Integumentary(skin) | Yes / No |
| Ears/Nose/Throat | Yes / No | Urinary | Yes / No |
| Cardiovascular | Yes / No | Endocrine | Yes / No |
| Respiratory | Yes / No | Blood/Lymph | Yes / No |
| High blood pressure | Yes / No | Allergic | Yes / No |
| Nervous system | Yes / No | Headaches | Yes / No |
| Muscles/Bones | Yes / No | Mental | Yes / No |

Please explain_____
Diabetes Yes / No Type_____ Date of Diagnosis_____/_____/_____
Allergies to medication? Yes / No Which?_____ Reactions_____
Other Health Problems_____
Current Medication(s)_____
Have you had any operations? Yes / No Kind_____ Date____/_____/_____
Name of family doctor_____ Date of last visit_____/_____/_____
Date of last tetanus shot_____/_____/_____
Do you have any eye conditions or problems?_____
Have you had any eye operations?_____ Date____/_____/_____
Have you had any eye injuries?_____ Date____/_____/_____
Do you have: (please circle yes or no)

| | | | | | |
|---|---|---|---|---|---|
| Macular Degeneration | Yes / No | Glaucoma | Yes / No | Cataracts | Yes / No |
| Blurred Vision | Yes / No | Do you wear glasses? | | Yes / No | |
| Retinal Detachment | Yes / No | Contact lenses? | | Yes / No | Type_____ |

**Family History** (Circle)

| | | |
|---|---|---|
| High blood pressure | Yes / No | Relation_____ |
| Macular Degeneration | Yes / No | Relation_____ |
| Retinal Detachment | Yes / No | Relation_____ |
| Diabetes | Yes / No | Relation_____ |
| Glaucoma | Yes / No | Relation_____ |
| Cataracts | Yes / No | Relation_____ |
| Cancer | Yes / No | Relation_____ |
| Hypo/Hyperthyroidism | Yes / No | Relation_____ |