



# Patient History Questionnaire

VSP ID# \_\_\_\_\_

Today's Date \_\_\_\_\_

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

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/No Referred By \_\_\_\_\_

Primary Vision Coverage \_\_\_\_\_ Secondary Coverage \_\_\_\_\_

## Medical Information

How is your general health? \_\_\_\_\_

Do you take medications for any of these systems? **(Please circle yes or no.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	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? \_\_\_\_\_ When? \_\_\_\_\_

Name of family doctor and/or primary care physician \_\_\_\_\_

Date of last visit \_\_\_\_\_ Date your blood pressure was last checked \_\_\_\_\_

## Family History

High blood pressure Yes/No Relation \_\_\_\_\_ Macular degeneration Yes/No Relation \_\_\_\_\_

Diabetes Yes/No Relation \_\_\_\_\_ Retinal detachment Yes/No Relation \_\_\_\_\_

Glaucoma Yes/No Relation \_\_\_\_\_ Cataracts Yes/No Relation \_\_\_\_\_

## Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? \_\_\_\_\_

Have you had any eye operations? Yes/No Type \_\_\_\_\_ Date \_\_\_\_\_

Have you had an eye injury? Yes/No Kind \_\_\_\_\_ Date \_\_\_\_\_

Do you have glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No

Macular degeneration? Yes/No Retinal detachment? Yes/No Blurred vision? Yes/No

Do you wear glasses? Yes/No Contact lenses? Yes/No Type \_\_\_\_\_

Additional information \_\_\_\_\_

## Doctor Use Only

Reviewed by \_\_\_\_\_  No changes Date \_\_\_\_\_

Reviewed by \_\_\_\_\_  No changes Date \_\_\_\_\_

Reviewed by \_\_\_\_\_  No changes Date \_\_\_\_\_