Council Opticians Patient History Questionnaire

Must be updated at each visit

Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Other Phone _____
Email Address _____ Preferred Method of contact Text / Phone _____ / Email
Date of birth _____ Occupation_____ Employer _____
Social Security Number _____
Emergency Contact Name _____ Phone Number _____
Date of Last Eye Exam_____ Dilated? Yes / No Referred By: _____
Primary Vision Coverage _____ Medical Coverage _____

Medical Information

What is your general health? _____
Do you have problems with 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) See Attached Medication List Yes / No

Have you had any operations? Yes/No Kind? _____
When? _____
Name of family doctor _____
Date of last visit_____ Health Care Proxy _____

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 Brand/Type_____
Additional information _____
Reviewed by_____ No changes Date _____
Reviewed by_____ No changes Date _____
Reviewed by_____ No changes Date _____
Reviewed by_____ No changes Date _____
Reviewed by_____ No changes Date _____