Preferred language? ______________

PATIENT QUESTIONAIRE

VSP ☐ Other ________

(Must be updated at each visit)

Last Name ______________ First Name ______________ MI ________
Address ______________ City ______________ Zip ________
Phone Hm ______________ Cell ______________ M ☐ F ☐ Date of Birth ______________ Age ____
ID / SS# ______________ e-mail ______________
Emergency Contact / Telephone ______________
Date of last eye exam ______________ Dilated? ______________ Today's Date ______________

Medical Information

What is your general health? ______________

Do you have problems with any of these systems?

Eyes Y / N
Gastrointestinal Y / N
Nervous Y / N
Mental Y / N
Ears/Nose/Throat Y / N
Genitourinary Y / N
Endocrine (glands) Y / N
Cardiovascular Y / N
Musculoskeletal Y / N
Blood/Lymph Y / N
Respiratory Y / N
Integumentary (skin) Y / N
Allergic/Immunologic Y / N

Please explain ______________

Please answer all that apply

Diabetes Y / N Type ________ Date of diagnosis ______________
Allergies Y / N Allergic to what? ______________ What happens? ______________
Medication allergy Y / N What happens? ______________
Headaches Y / N
Other health problems ______________
Current medication(s) ______________
Have you had any operations? Y / N Kind? ______________ When? ______________
Do you use cigarettes/tobacco? ________ Alcohol? ________ Other substance? ________
Name of family doctor ______________ 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 ________
Other eye conditions Y / N What kind? ______________ Relation ______________

Personal Eye Information

Have you had any eye operations? Y / N Type ______________ Date ________
Have you had any eye injury? Y / N Kind ______________ Date ________
Do you have glaucoma? Y / N Cataracts? Y / N Dry eyes? Y / N Blurred vision? Y / N
Other eye problems? Y / N What kind? ______________
Do you wear glasses? Y / N Contact lenses? Y / N Type ______________
Additional information ______________
Whom may we thank for referring you? ______________
Doctors initials ______________