

## Patient History Questionnaire

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Work Phone ( ) \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Email Address \_\_\_\_\_  
DOB \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Emergency contact name \_\_\_\_\_ Phone number ( ) \_\_\_\_\_  
Date of last eye exam \_\_\_\_\_ Dilated? Yes / No  
Today's date \_\_\_\_\_ Referred by \_\_\_\_\_

### Medical Information

How 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	Muscle / Bone	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 medications? Yes / No Which? \_\_\_\_\_ Reactions? \_\_\_\_\_  
Other health problems \_\_\_\_\_  
Current medications \_\_\_\_\_ Check if none   
Have you had any operations? Yes / No Kind? \_\_\_\_\_ When? \_\_\_\_\_  
Name of family doctor \_\_\_\_\_  
Date of last visit \_\_\_\_\_ Date of last tetanus shot \_\_\_\_\_

### Family History

Cataracts	Yes / No	Relation _____	Macular degeneration	Yes / No	Relation _____
Diabetes	Yes / No	Relation _____	Retinal detachment	Yes / No	Relation _____
Glaucoma	Yes / No	Relation _____	High Blood Pressure	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 \_\_\_\_\_

### ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. David Kirschen's Notice of Privacy Practices

Patient Name \_\_\_\_\_ Legal Guardian \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_