

# BLANCHARD FAMILY EYE CARE, PC

## PATIENT HISTORY QUESTIONNAIRE

Date \_\_\_\_\_

### Please answer all questions

Last name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
Emergency contact/Telephone Number \_\_\_\_\_  
Date of last exam \_\_\_\_\_ Where/Phone # \_\_\_\_\_ Dilated Yes or No

### Medical Information

What is your general health? \_\_\_\_\_  
Do you have problems with any of these symptoms? (please circle all that apply)      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 \_\_\_\_\_  
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 Describe \_\_\_\_\_  
Do you use cigarettes/tobacco? \_\_\_\_\_ Alcohol? \_\_\_\_\_ Other Substance(s)? \_\_\_\_\_  
Name of family doctor \_\_\_\_\_ Phone # \_\_\_\_\_  
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 condition(s) Y/N      What kind? \_\_\_\_\_

### Personal Eye Information

Have you had any eye operations?      Y/N      Type \_\_\_\_\_      Date \_\_\_\_\_  
Have you had an eye injury?      Y/N      Kind \_\_\_\_\_      Date \_\_\_\_\_  
Do you have glaucoma?      Y/N      Cataracts?      Y/N      Dry Eyes?      Y/N      Blurred Vision?      Y/N  
Do you wear glasses?      Y/N      Contact lenses?      Y/N      Type \_\_\_\_\_

Additional Information \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

Doctor's initials \_\_\_\_\_