Patient's Name: _____ MRN: _____

Date: _____

PATIENT HISTORY QUESTIONNAIRE

MEDICAL INFORMATION
SYSTEMS REVIEW

Do you have problems with any of these systems?

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

Please explain_____
_____

Are you currently taking any medications or supplements? Y N

List all known allergies to medications_____
_____

List all past surgeries_____

SOCIAL HISTORY

Do you use cigarettes / tobacco? Y N

Do you use alcohol? Y N

Do you use other substances? Y N

Occupation_____

PERSONAL EYE INFORMATION

Have you had any eye operations?	Y N	Type:_____	Date_____
Have you had an eye injury?	Y N	What kind?_____	Date_____
Do you have glaucoma?	Y N	Cataracts? Y N Dry Eyes? Y N	
Other eye problems?	Y N	What kind?_____	
Do you wear glasses?	Y N	Contact Lenses? Y N	Type_____
Are you considering LASIK?	Y N	Reason why?_____	