DE BOER FAMILY EYECARE
PATIENT HISTORY QUESTIONAIRE

PATIENT INFORMATION: Today's Date ____/____/_____

Name _____ Name of Spouse _____

Address _____ Phone _____

City/State _____ ZIP _____ Work Phone _____

Birth Date ___/___/_____ Social Security# ____-____-_____ Full time student? Y / N

Employer _____ Occupation _____

Name of Medical Doctor: _____ Dr.'s Phone# _____

Last Medical Exam ____/____/_____ Last Eye Exam ____/___/_____

RESPONSIBLE PARTY INFORMATION:

Name _____ Date of Birth ____/____/_____

Social Security# ____-____-_____ Employer _____

Medical History

Do you have any allergies to medications? ☐ No ☐ Yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

List all major injuries, surgeries, and / or hospitalizations you have had: _____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease,

Cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? No ☐ Yes ☐

Do you wear glasses? No ☐ Yes ☐ If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? No ☐ Yes ☐ If yes, how old is your present pair of lenses? _____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended wear ☐ Other Are they comfortable ☐ yes ☐ no

Family History

Please note any family history (parents, grandparents, siblings, children (living or deceased) for the following conditions:

DISEASE/CONDITION	*NO*	*YES*	*?*	*RELATIONSHIP TO YOU*
Blindness	☐	☐	☐	
Cataract	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment/Disease	☐	☐	☐	
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other _____	☐	☐	☐	

Please turn this form over and complete side two