

DE BOER FAMILY EYECARE PATIENT HISTORY QUESTIONNAIRE

PATIENT INFORMATION:

Name _____ Today's Date ____/____/____
 Address _____ Name of Spouse _____
 City/State _____ ZIP _____ Phone _____
 Birth Date ____/____/____ Social Security# ____-____-____ Work Phone _____
 Employer _____ Full time student? Y / N
 Name of Medical Doctor: _____ Occupation _____
 Last Medical Exam ____/____/____ Dr.'s Phone# _____
 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please turn this form over and complete side two