

Keller Eye Associates

Patient History Questionnaire

PLEASE ANSWER ALL QUESTIONS FOR THIS FORM WILL BE REVIEWED AT EACH APPOINTMENT.

Mr. Dr. Ms. Mrs. Miss

Date _____

Last Name _____ First Name _____

Date of Birth _____ Age _____ Date of Last Eye Exam _____

Address _____ City _____ Zip _____

Home phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Parent or Guardian (if under 18) _____ Name of Spouse _____

Are any other relatives seen here? If so, please list _____

Emergency Contact Name _____ Phone Number _____

Referred By _____

MEDICAL INFORMATION

What is your general health? _____

Do you have problems with any of these systems? (If yes, please check box)

- | | | | |
|---|--------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Nervous | <input type="checkbox"/> Endocrine | <input type="checkbox"/> Ears/Nose/Throat |
| <input type="checkbox"/> Urinary | <input type="checkbox"/> Blood/Lymph | <input type="checkbox"/> Respiratory | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Mental | <input type="checkbox"/> Eyes | |

Are you pregnant or nursing? no yes

Do you have any allergies to medications? no yes If yes, explain _____

List **any** medications you take (including over the counter) _____

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

List any eye conditions you have had in the past _____

Are you interested in Lasik? yes no Do you wear glasses? yes no

Do you wear contacts? yes no If no, are you interested in a contact lens evaluation yes no

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

DISEASE/CONDITION

Blindness no yes

Cataract no yes

Glaucoma no yes

Macular Degeneration no yes

Diabetes no yes

Cancer no yes

Thyroid Disease no yes

Arthritis no yes

High Blood Pressure no yes

Other _____ no yes

RELATIONSHIP TO YOU
