Keller Eye Associates

Patient History Questionnaire

Date _____

PLEASE ANSWER ALL QUESTIONS FOR THIS FORM WILL BE REVIEW AT EACH YEARLY APPOINTMENT

Dr. Mr. Mrs. Ms. Miss Single Married Divorced Widowed

Last Name _____ First Name _____ Nickname:_____

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

Address _____ Apt# _____ City _____ Zip _____

Best Contact # _____ Work # _____ Email _____

Employer _____ Occupation _____

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

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

Emergency Contact _____ Phone Number _____ Relation _____

Referred by _____

MEDICAL INFORMATION

How is your general overall health? _____

Do you have any problems with any of the following systems (if yes, check box)

☐ Gastrointestinal	☐ Nervous	☐ Endocrine	☐ Ears/Nose/Throat
☐ Urinary	☐ Blood/Lymph	☐ Respiratory	☐ Skin
☐ Headaches	☐ Mental	☐ Eyes	

Are you pregnant or nursing? ☐ No ☐ Yes How many weeks? _____ How old is child? _____

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

_____

List any eye conditions you have had _____

Have you had Lasik? Yes / No Year: _____ Have you had Cataract Surgery? Yes / No Year: _____

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 today? ☐ Yes ☐ No

Please note any family history for the following conditions: (Self, Parents, Grandparents, siblings, children; living or deceased)

DISEASE/CONDITION	Circle one		RELATIONSHIP TO YOU
Arthritis	No	Yes	_____
Blindness	No	Yes	_____
Cancer (Type_____)	No	Yes	_____
Cataract	No	Yes	_____
Diabetes (Type I / Type II)	No	Yes	_____
Glaucoma	No	Yes	_____
High Blood Pressure	No	Yes	_____
Macular Degeneration	No	Yes	_____
Thyroid Disease	No	Yes	_____
Other_____	No	Yes	_____