PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Provided by your VSP Network Doctor

Last name ______ First name ______
Address ______ City ______
State ______ Zip ______
Work phone ( ) ______ Home phone ( ) ______ Member ID # ______
DOB ______ Occupation ______ Employer ______
Emergency contact name ______ Phone number ( ) ______
Date of last eye exam ______ Dilated? ❑ Yes ❑ No
Today's date ______ Referred by ______

MEDICAL INFORMATION

What is your general health? ______
Do you have problems with any of these systems? (If yes, please check the box.)

❑ Gastrointestinal ❑ Nervous ❑ Endocrine
❑ Ears/Nose/Throat ❑ Urinary ❑ Blood/lymph
❑ Respiratory ❑ Integumentary (skin) ❑ Headaches
❑ High blood pressure ❑ Eyes ❑ Mental

Please explain ______
Diabetes ❑ Yes ❑ No Type ______
Allergies to medication? ❑ Yes ❑ No Which? ______ Reactions? ______
Other health problems ______
Current medication(s) ______ Check if none ❑
Have you had any operations? ❑ Yes ❑ No Kind? ______ When? ______
Name of family doctor ______
Date of last visit ______ Date of last tetanus shot ______

FAMILY HISTORY

❑ High blood pressure Relation ______ ❑ Macular degeneration Relation ______
❑ Diabetes Relation ______ ❑ Retinal detachment Relation ______
❑ Glaucoma Relation ______ ❑ Cataracts Relation ______

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? ❑ Yes ❑ No What kind? ______
Have you had any eye operations? ❑ Yes ❑ No Type ______ Date ______
Have you had an eye injury? ❑ Yes ❑ No Kind ______ Date ______
Do you have glaucoma? ❑ Yes ❑ No Cataracts? ❑ Yes ❑ No Dry eyes? ❑ Yes ❑ No
Macular degeneration? ❑ Yes ❑ No Retinal detachment? ❑ Yes ❑ No Blurred vision? ❑ Yes ❑ No
Do you wear glasses? ❑ Yes ❑ No Contact lenses? ❑ Yes ❑ No Type ______
Additional information ______

DOCTOR USE ONLY

Reviewed by ______ ❑ No changes Date ______
Reviewed by ______ ❑ No changes Date ______
Reviewed by ______ ❑ No changes Date ______