KEMPERAS EYECARE PATIENT HISTORY QUESTIONNAIRE

Last Name _____ First Name _____ MI ____

Date of Last Eye Exam ___/___/_____ Dilated? Yes/No

Medical Information:

Do you have problems with any of these systems? (Please circle any that apply)

Gastrointestinal	Nervous	Endocrine (glands)
Ears/Nose/Throat	Urinary	Blood/lymph
Cardiovascular	Muscles/Bones	Allergic/immunologic
Respiratory	Integumentary (skin)	Headaches/Neoro
High blood pressure	Constitutional (weight)	Mental

Please Explain _____

Diabetes Yes/No Type _____ Date of Diagnosis ___/___/_____

Allergies to medication? Yes/No Which? _____ Reactions? _____

Other health problems _____

Current medication(s) _____

Have you had any operations? Yes/No Kind? _____When? _____

Name of family doctor _____ Date of last visit ___/___/_____

Family History (Please circle and specify relation to any that apply):

High blood pressure	Relation _____	Macular Degeneration	Relation _____
Diabetes	Relation _____	Retinal Detachment	Relation _____
Thyroid Disease	Relation _____	Cataracts	Relation _____
Cancer	Relation _____	Glaucoma	Relation _____

Personal Eye Information (Please circle any that apply):

Wear glasses	Cataracts	Retinal Detachment
Dry Eyes	Glaucoma	Macular Degeneration
Blurred vision	Contacts	Type of Contacts _____

Do you have any other eye conditions or problems? Yes/No What Kind? _____

Have you had any eye operations? Yes/No Type _____ Date ___/___/_____

Have you had any eye injury? Yes/No Type _____ Date ___/___/_____

Social History:

Do you drive? Yes/No Drink alcohol? Yes/No Use tobacco products? Yes/No

Other recreational drugs? Yes/No _____ Been infected with a STI/STD? Yes/No

Signature _____ Date ___/___/_____