VisionCare Optometry Of Elk Grove

Patient History Questionnaire

Preferred Language_____ Today's Date_____

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

Last Name _____ First Name _____ MI____ Gender (M/F)_____
Address _____ City _____ State_____ Zip_____
Work Ph: _____ Home Ph: _____ Mobile Ph: _____Text ok?(Y/N)_____
Date of Birth _____ Occupation _____ Employer/School _____
Emergency Contact Name _____ Phone Number _____ Relationship _____
Date of Last Eye Exam _____ Dilated? Yes / No Referred By _____ Race/Ethnicity_____
Primary Vision Coverage_____ID Number_____ Secondary Coverage _____
Medical Coverage _____ Email Address*_____

*used to communicate and inform.

Medical Information

How is your general health? _____ Do you smoke? Yes/No
Do you take medications for any of these systems? (Please circle yes or no.)

Gastrointestinal	Yes / No	Nervous	Yes / No	Endocrine (glands)	Yes / No
Ears/Nose/Throat	Yes / No	Urinary	Yes / No	Blood/Lymph	Yes / No
Cardiovascular	Yes / No	Muscles/Bones	Yes / No	Allergic/Immunologic	Yes / No
Respitory	Yes / No	Integumentary (Skin)	Yes / No	Headaches	Yes / No
High Blood Pressure	Yes / No	Eyes	Yes / No	Mental	Yes / No

Please Explain _____
Diabetes? Yes / No _____Type? _____ Date of Diagnosis _____
Allergies to Medications? Yes / No -Which? _____ Reactions? _____
Other Health Problems _____
Current Medication(s) Use backside if needed _____
Have you had any operations? Yes / No- Kind? _____ When? _____
Name of Family Doctor and/or Primary Care Physician _____
Date of Last Visit _____Latest Blood Pressure Reading _____Height_____Weight_____

Family History

High Blood Pressure	Yes / No	Relation_____	Macular Degeneration	Yes / No	Relation_____
Diabetes	Yes / No	Relation_____	Retinal Detachment	Yes / No	Relation_____
Glaucoma	Yes / No	Relation_____	Cataracts	Yes / No	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 you would like to inform the Doctor of _____

Doctor Use Only

Reviewed by _____ Changes Yes / No Date _____
Reviewed by _____ Changes Yes / No Date _____
Reviewed by _____ Changes Yes / No Date _____