CERRITOS 20/20 OPTOMETRY

Patient History Questionnaire

Today's Date ____________________

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

Last Name ________________________________ First Name ____________________________ MI________
Address __________________________ City _________________________ State _______ Zip _________
Work Phone ___________________ Home Phone ____________________ Cell Phone ___________________
Date of Birth _____________ Occupation __________________________ Employer _____________________
Emergency Contact Name _____________________________ Phone Number __________________________
Date of Last Eye Exam _______________ Dilated? Yes/No Referred By ______________________________
Primary Vision Coverage ______________________ Secondary Coverage _____________________________

Communication

E-Mail: ____ Texting: Yes/No

Medical Information

How is your general health? ____
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
Respiratory	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 medication Yes/No Which? ______________________ Reactions? _________________________
Other health problems ____
Current medication(s) ____
Have you had any operations? Yes/No Kind? _________________________________ When? _____________
Name of family doctor and/or primary care physician ____
Date of last visit __________________________ Date your blood pressure was last checked _______________

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 Type ______________________________________ 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 ____

Social History

Tobacco use: Do you smoke? Yes/No If yes, how frequently? ____
Do you drink alcohol? Yes/No If yes, how frequently? ____
Do you use recreational drugs? Yes/No

Doctor Use Only
Reviewed by __________________________________ No changes Date _______________