Today's Date_____

DR. TERRY K. ISBILL, OPTOMETRIST

PATIENT HISTORY QUESTIONNAIRE

Last Name_____First Name_____MI_____
Address_____City_____State___Zip_____
Work Phone_____Home 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_____

Medical Informaton

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
Ear/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 of last blood pressure check_____

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	Retinal detachment?	Yes/No
Macular degeneration?	Yes/No	Dry eyes?	Yes/No
Do you wear glasses?	Yes/No	Blurred vision?	Yes/No
Cataracts?	Yes/No	Contact lenses?	Yes/No Type_____

Doctor Use Only_____
Reviewed by_____ ◯ No changes Date_____
Reviewed by_____ ◯ No changes Date_____

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