GLENDORA OPTOMETRIC VISION CENTER

PATIENT HISTORY QUESTIONNAIRE

(Completion required at each patient appointment)

CONTACT LENS WEARERS MAY INCUR ADDITIONAL FITTING FEES

Please answer all questions.

Last name _____ First name _____ MI _____

Address _____ City _____ Zip _____

Telephone (W) _____ (H) _____

SSN ___ – ___ – ___ Date of birth _____ Male (M) or Female (F) _____

If a minor, responsible party _____

Occupation _____ Driver's License # _____

Employer _____

Emergency contact/Telephone number _____

Date of last eye exam _____ Dilated? _____ Today's date _____

Whom may we thank for referring you? _____

Medical Information

What is your general health? _____

Do you have problems with any of these systems? *(please circle all that apply)*

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine (glands)	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Blood/lymph	Y/N
				Allergic/immunologic	Y/N

Please explain _____

Diabetes? Y/N Type _____ Date of diagnosis _____

Allergies? Y/N Allergic to what? _____ What happens? _____

Medication allergy? Y/N What happens? _____ Headaches? Y/N

Other health problems _____

Current medication(s) _____

Have you had any operation? Y/N Kind? _____ When? _____

Name of family doctor _____ Date of last visit _____

Date of last tetanus shot _____

Family History

High blood pressure?	Y/N Relation _____	Macular degeneration?	Y/N Relation _____
Diabetes?	Y/N Relation _____	Retinal detachment?	Y/N Relation _____
Glaucoma?	Y/N Relation _____	Cataracts?	Y/N Relation _____

Personal Eye Information

Other eye condition(s)? Y/N What kind? _____ Date _____

Have you had any eye operations? Y/N Type _____ Date _____

Have you had an eye injury? Y/N Kind _____ Date _____

Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred vision? Y/N

Other eye problems? Y/N What kind? _____

Do you wear glasses? Y/N Contact lenses? Y/N Type _____

Additional information _____

Doctor's initials

PLEASE NOTE: In order to maintain our low fees we must adopt the following office policy. We cannot be responsible for delays due to lab breakage and/or manufacturer's back orders. Orders cancelled during lab processing will be charged a 25% handling fee. Orders not picked up within 60 days of completion will forfeit the deposit. All returned checks will incur a $25.00 charge.

Patient's signature _____ Date _____