



PATIENT HISTORY QUESTIONNAIRE

(must be updated at each visit)

Name: _____ Birth Date: _____ Today's Date: _____
 Address _____ City/State _____ Zip Code _____
 Telephone (H) _____ (W) _____ (Cell) _____ Email _____
 SSN _____ - _____ - _____ Occupation: _____ Employer _____
 How did you hear about us (DCO)? _____

MEDICAL INFORMATION

Main reason(s) for today's visit: _____
 Are you planning to update your (check all that apply) _____ Glasses _____ Contact Lenses _____ Sunglasses _____ Work Glasses _____
 Are you interested in Laser Vision Correction? _____ Yes _____ No _____ Maybe in the near future _____ Performed on _____
 Do you wear glasses (circle one)? Y N How old is/are you current pair(s)? 1. _____ years old 2. _____ years old 3. _____
 Do you wear Contact Lenses? Y N If yes (check all that apply): _____ Full Time _____ Part Time _____ Hard _____ Soft _____ Disp. _____
 CL Brand/Model: _____ Current CL's are how old? _____
 Last Eye Exam Date: _____ Previous Eye Dr. _____ Located in: _____

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

Ears/Nose/Throat	Y/N	Neurological	Y/N	Psychiatric	Y/N
Sinus Congestion	Y/N	Head Aches	Y/N		
Chronic Cough	Y/N	Migraines	Y/N		
		Seizures	Y/N		
Gastrointestinal	Y/N	Genitourinary	Y/N	Endocrine (glands)	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/lymph	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Allergic/Immunologic	Y/N

Please explain _____
 Please answer all that apply:
 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 operations? Y/N Kind? _____ When? _____
 Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substance(s) _____
 Name/Address of family doctor _____
 Date of last visit _____ Date of next visit _____

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 _____
Other eye conditions(s) Y/N What kind? _____	Relation _____

PERSONAL EYE INFORMATION

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? _____ Blurred vision? Y/N
 Other eye problems Y/N What kind? _____
 Do you wear glasses? Y/N Contact lenses Y/N Type _____
 Do you use a computer? Y/N At work? _____ At home? _____ How many hours per day? _____
 Hobbies/Sports? _____
 Whom may we thank for referring you? _____

Patient History
QUESTIONNAIRE

I acknowledge that I received a copy of Daly City Optometry's Notice of Privacy Practices.

Signature x _____ Today's Date _____
 (Guardian's signature if patient is a minor)