PATIENT HISTORY QUESTIONNAIRE

(Must be updated at each visit)

GOLDEN OPTOMETRIC
DAVID B. GOLDEN, O.D. • SHELDON M. GOLDEN, O.D.

Today's Date _____

Please circle one: Dr. Mr. Mrs. Ms. Miss SS# (of patient) _____-_____-_____

First Name _____ MI_____ Last Name _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____x _____ Cell (____) _____ - _____

Date of Birth _____/_____/_____ Date of Last Exam _____/_____/_____ Were you dilated? Yes No

E-Mail Address

Occupation _____ Employer _____ Flex Spending Acct.? Y / N

Name of Vision Insurance: VSP MESC EYEMED NVA SAFEGUARD MEDICARE MEDI-CAL OTHER_____

Name (of insured) _____ SS # (of insured) _____-_____-_____ DOB (of insured) _____

Name of Major Medical Insurance: _____

Name (of insured) _____ SS # (of insured) _____-_____-_____ DOB (of insured) _____

MEDICAL INFORMATION

How is your general health? _____

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

				Eyes	Y / N
Gastrointestinal	Y / N	Nervous	Y / N	Mental	Y / N
Ears/Nose/Throat	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 to you:

Diabetes Y / N Type: _____ Date of diagnosis: _____

Allergies to any medications? Y / N Which Medications? _____ What Happens? _____

Sinus/Seasonal Allergies? Y / N Headaches? Y / N High blood pressure? Y / N High Cholesterol? Y / N

Other health problems _____

List all current medications _____

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

Do you use cigarettes / tobacco? Y / N Alcohol? Y / N Other substance(s) _____

Name of family doctor: _____ Date of last visit: _____

Date of last tetanus shot _____ Are you, or could you be pregnant? Y / N How many weeks? _____

FAMILY HISTORY

Diabetes	Y / N	Relation_____	Macular degeneration	Y / N	Relation_____
High Blood Pressure	Y / N	Relation_____	Retinal detachment	Y / N	Relation_____
Glaucoma	Y / N	Relation_____	Cataracts	Y / N	Relation_____
Other eye condition(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? Y / N Blurred vision? Y / N

Other eye problems? Y / N What kind? _____ Do you wear glasses? Y / N

Do you wear contact lenses? Y / N Type _____ How often do you sleep in your contact lenses? Often Sometimes Never

How did you hear about our office? Google ◆ Yelp ◆ Facebook ◆ Yellow Pages ◆ Postcard ◆ Walk-in ◆ VSP Website

Internet (other): Friend:

INFORMATION UPDATE ONLY Doctor's Review Initials:_____

1. Patient's initials_____	2. Patient's initials_____	3. Patient's initials_____	4. Patient's initials_____
Updated date _____	Updated date _____	Updated date _____	Updated date _____
Doctor's initials _____	Doctor's initials _____	Doctor's initials _____	Doctor's initials _____