Patient History Questionnaire – Burbank Family Optometry, Inc.

Last name _____ First name _____ MI _____ **Today's Date** _____

Address _____

City _____ **Zip Code** _____ State ____ Age _____ Date of Birth __/__/__

Telephone (CELL)(preferred) _____ (OTHER: home…work) _____

Emergency contact Tel. # _____ Date of last eye exam_____

Social Security # _____/____/_____ Occupation _____

Are you thinking of getting new glasses, today?…Y….N

Are you thinking of getting new contact lenses, today?…Y…N

Are you thinking of getting new sun glasses, today?…Y…N

Please give us your primary medical Doctor's name & address:

Chief Complaint: ***Please circle any signs &/or symptoms you are experiencing:*** loss of vision, headaches, eye redness, eye pain, eye itching, burning, floaters, dry eyes, other _____

To serve you better: Email address: _____@ _____

Medical Information

***Personal Eye Information*:**

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

Have you had any eye injuries?…Y/N…Kind _____Date ___/___/___

Do you have:

Glaucoma?…Y/N… Cataracts?…Y/N… Dry Eyes?…Y/N… Blurred Vision?…Y/N

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

Any other eye problems or additional information we should know (Please use other side)

Please circle any of the following with which you have any problems:

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

Do you have high cholesterol? _____ **What are you doing for it?** _____

***Please answer all that apply*:**

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

Medication allergies…Y/N…What happens? _____

Other allergies…Y/N…To what? _____ What happens? _____

Headaches…Y/N…Any other health problems? _____

Current medications & Vitamins_____ (other side, if necessary)

Have you had any operations?…Y/N What types & when? Please use other side of page.

Do you use cigarettes/tobacco?…Y/N…. Alcohol?….Y/N…. Other substances?…Y/N

Name of family doctor _____ Date of last visit ___/___/____

Family History:

Thyroid Disease…Y/N…Who? _____ Lupus…Y/N…Who? _____

High blood pressure…Y/N…Who? _____ Macular Degeneration…Y/N…Who? _____

Diabetes…Y/N…Who? _____ Retinal Detachment…Y/N…Who? _____

Glaucoma…Y/N…Who? _____ Cataracts…Y/N…Who? _____

Other eye conditions? _____Who? _____

Whom may we thank for referring you? _____