Dr. Ruth Bonander

Today's Date _____

PATIENT HISTORY QUESTIONNAIRE

(Must be updated at each visit)

Last name_____First name _____M.I. _____

Address_____

Telephone (work)_____ (home) _____

Social Security Number_____ - _____ - _____Date of Birth_____

Occupation _____Employer _____

Hobbies _____

Emergency contact Name/Telephone No. _____

MEDICAL INFORMATION

What is your general health?_____

Do you have problems with any of these systems? (Please circle "yes or no" on all) Eyes Y / N

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

Please explain _____

Please answer all. And if yes, complete line:

Diabetes Y /N Type_____Date of Dianosis_____

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

Medication allergy Y /N Allergic to what? _____What happens?_____

Headaches Y /N Describe Headache _____

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 of family doctor _____Date of last visit _____

Date of last tetanus shot _____

Do you have an Advance Directive for health care?_____

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 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 Contact lenses? Y /N Type_____

Additional information_____

Whom may we thank for referring you? _____

Doctor's Initials_____