Today's Date: _____

James L. Abbott, O.D., P.C.

PATIENT HISTORY QUESTIONNAIRE

(Completion required at each appointment)

Name: Last_____ First_____ MI_____ M/F

Address_____ City_____ State_____ Zip_____

How would you like to be contacted? (Please Circle)

Telephone (H) _____ (cell/work) _____

Email Address_____

Date of Birth_____

Occupation_____ Employer_____

Emergency Contact/Telephone Number_____

Date of Last Exam_____ Dilated? Y / N

Parent / Guardian Name: _____

Marital Status_____ Name of Spouse: _____

Reason of Visit: _____

PERSONAL VISION INFORMATION

Have you had any eye operations / injuries? Y / N Type_____ Date_____

Do you have: Glaucoma? Y / N Cataracts? Y / N Dry Eyes? Y / N Blurred Vision? Y / N

Other eye problems? Y / N if yes, what kind? _____Date_____

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

Additional Information: _____

Whom may we thank for referring you? _____

MEDICAL INFORMATION

What is your general health? _____

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

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

If Yes, Please Explain_____

Please answer all that apply:

Allergies Y / N To What? _____ Reaction: _____

Medication Allergies Y / N What? _____Reaction: _____

Headaches? Y / N

Other Health Problems: _____

Current Medication(s): _____

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

Do you use tobacco? _____ Alcohol? _____ Other? _____

Name of Family Doctor: _____ Date of Last 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 condition(s)?	Y / N	Relation_____

Doctor Initials: _____ Patient Initial: _____