SUMNER
PRIMARY EYECARE

PATIENT HISTORY QUESTIONNAIRE

Today's date _____

Last Name _____ First Name _____ MI _____ Nickname _____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ (Home / Cell / Work) Secondary Phone _____ (Home / Cell / Work)

☐ I allow Sumner Primary Eyecare to send an appointment reminder via email or text message.

Email address _____ Marital status _____

Date of Birth _____ Sex _____ Social Security Number _____

Occupation _____ Employer _____

Emergency Contact Name _____ Phone Number _____ Relationship _____

Name of family doctor and/or primary care physician _____ Phone number _____

MEDICAL INFORMATION

How is your general health? _____

Tobacco Use: ☐Never smoked If you have quit, at what age? ____ Average packs/day? ____ At what age did you start? ____

Alcohol Use: ☐None What is your weekly intake? _____

Do you take medications for any of these systems? **(Please circle yes or no)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (Skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain _____

Diabetes? Yes ☐ No ☐ Type _____ Date of diagnosis _____

Allergies to medication? Yes ☐ No ☐ Which? _____ Reactions? _____

Other health problems _____

Current medication(s) _____

_____

Have you had any surgeries? Yes ☐ No ☐ Kind? _____ Date _____

_____

FAMILY HISTORY

High blood pressure	Yes/No	Relation _____	Macular degeneration	Yes/No	Relation _____
Diabetes	Yes/No	Relation _____	Retinal detachment	Yes/No	Relation _____
Glaucoma	Yes/No	Relation _____	Cataracts	Yes/No	Relation _____

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? Yes ☐ No ☐ What kind? _____

Have you had any eye surgeries? Yes ☐ No ☐ Type _____ Date _____

Have you had an eye injury? Yes ☐ No ☐ Type _____ Date _____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contact lenses?	Yes/No	Type _____	