

# Benchmark Optical Patient History Questionnaire

Today's date \_\_\_\_\_ Please check one:  new  returning  
(Completion required at each patient appointment)

Last name \_\_\_\_\_ First name \_\_\_\_\_ Middle \_\_\_\_\_  
Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_  
E-Mail \_\_\_\_\_ Emergency contact/phone \_\_\_\_\_  
Date of birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Age \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Date of last eye exam \_\_\_\_\_ Eye doctor \_\_\_\_\_ Dilated?  yes  no  
Name of person responsible for this account \_\_\_\_\_

self,  spouse,  parent,  guardian

**See: Insurance Information Form** after supplying the following medical information

## Medical Information

What is your general health? \_\_\_\_\_

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Gastrointestinal    | <input type="checkbox"/> Nervous              | <input type="checkbox"/> Eyes               |
| <input type="checkbox"/> Ears/Nose/Throat    | <input type="checkbox"/> Genitourinary        | <input type="checkbox"/> Mental             |
| <input type="checkbox"/> Cardiovascular      | <input type="checkbox"/> Musculoskeletal      | <input type="checkbox"/> Endocrine (glands) |
| <input type="checkbox"/> Respiratory         | <input type="checkbox"/> Integumentary (skin) | <input type="checkbox"/> Blood/Lymph        |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Allergic/Immunologic | <input type="checkbox"/> Headaches          |

Please explain: \_\_\_\_\_

Please check (✓) and answer all that apply:

Diabetes:  yes  no,  Type I  Type II, Date of diagnosis \_\_\_\_\_

Allergies:  yes  no, Allergic to what? \_\_\_\_\_ What happens? \_\_\_\_\_

Medication allergy:  yes  no, Allergic to what? \_\_\_\_\_ What happens? \_\_\_\_\_

Other health problems \_\_\_\_\_

Current medications \_\_\_\_\_

Have you had any operations?  yes  no, Kind? \_\_\_\_\_ When? \_\_\_\_\_

Do you use cigarettes?  yes  no, Alcohol?  yes  no, Other substances?  yes  no

Name of family doctor \_\_\_\_\_ Date of last visit \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Family History	Relation:	Relation:
High blood pressure <input type="checkbox"/> yes <input type="checkbox"/> no	_____	Macular Degeneration <input type="checkbox"/> yes <input type="checkbox"/> no _____
Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no	_____	Retinal Detachment <input type="checkbox"/> yes <input type="checkbox"/> no _____
Glaucoma <input type="checkbox"/> yes <input type="checkbox"/> no	_____	Cataracts <input type="checkbox"/> yes <input type="checkbox"/> no _____
Other eye condition(s) <input type="checkbox"/> yes <input type="checkbox"/> no, What kind?	_____	Relation: _____

## Personal Eye Information

Have you had any eye operations?  yes  no, Kind? \_\_\_\_\_, Date \_\_\_\_\_

Have you had an eye injury?  yes  no, Kind? \_\_\_\_\_, Date \_\_\_\_\_

Do you have Glaucoma?  yes  no, Cataracts?  yes  no,

Blurred vision?  yes  no, Dry eyes?  yes  no,

Other eye problems?  yes  no, What kind? \_\_\_\_\_

Do you wear glasses?  yes  no, Contact lenses?  yes  no

Additional information \_\_\_\_\_

Doctor's initials \_\_\_\_\_