Utah Eye Associates
State-of-the-art medical and general eyecare

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Website: www.UtahEyeAssociates.com

Date: _____

PATIENT HISTORY QUESTIONAIRE

Last Name_____ First Name _____ MI _____
Address_____ City _____ State _____ Zip _____
Work Phone _____ Home Phone _____ Cell Phone _____
Date of Birth _____ Occupation_____ Employer_____
Sex ❑M ❑F Marital Status _____ Referred by _____
Emergency Contact _____ Ethnicity _____ Email _____

Medical Information

Do you have problems in the following areas? (Please check 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	Skin	❑ Yes	❑ No	Headaches	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	Eyes	❑ Yes	❑ No	Mental	❑ Yes	❑ No

Please explain _____
Diabetes ❑ Yes ❑ No Type_____ Years diagnosed _____ HbA1c _____ Controlled _____
Current medications _____

_____
Medications allergy or seasonal _____
Name and Address of Family doctor_____ Phone number _____
Surgeries _____

Family History

High blood pressure	❑ Yes	❑ No	Relation _____	Macular Degeneration	❑ Yes	❑ No	Relation _____	
Diabetes	❑ Yes	❑ No	Relation _____	Retinal Degeneration	❑ Yes	❑ No	Relation _____	
Glaucoma	❑ Yes	❑ No	Relation _____	Cataracts	❑ Yes	❑ No	Relation _____	
Alzheimer's	❑ Yes	❑ No	Relation _____	Parkinson's	❑ Yes	❑ No	Relation _____	

Personal Eye Information

Describe your eye problem _____
Have you had any eye surgery ❑ Yes ❑ No Describe _____
Have you had any eye injury ❑ Yes ❑ No Describe _____

Do you have any of the following?

Glaucoma	❑ Yes	❑ No	Cataracts	❑ Yes	❑ No	Dry Eyes	❑ Yes	❑ No
Macular degeneration	❑ Yes	❑ No	Retinal degeneration	❑ Yes	❑ No	Flashes/Floaters	❑ Yes	❑ No
Sandy, gritty feeling	❑ Yes	❑ No	Watery/itchiness	❑ Yes	❑ No	Blurred vision	❑ Yes	❑ No
Have you had LASIK	❑ Yes	❑ No	Do you wear glasses	❑ Yes	❑ No	Contact lenses	❑ Yes	❑ No

Smoke or Drink: ___ _____

Doctor Use Only

Reviewed by _____ Any changes ❑ Yes ❑ No Date _____
Reviewed by _____ Any changes ❑ Yes ❑ No Date _____
Reviewed by _____ Any changes ❑ Yes ❑ No Date _____