Patient History Questionnaire
Iris Y. Kuwabara, O.D.

Last Name__________________________________ First Name_____________________ MI____

Medical Information

What is your general health?____
Do you have problems with 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/Immune	yes/no
Respiratory	yes/no	Skin	yes/no	Headaches	yes/no
High Blood Press.	yes/no	Eyes	yes/no	Mental	yes/no

Please explain____
Diabetes yes/no Type___________ Date of Diagnosis______________________________
Allergies to medications? yes/no Which?____
Other health problems____
Current medication(s)____
Have you had any operations? yes/no Kind?____
Name of family doctor____
Date of last visit_______________________________ Date of last tetanus shot______________________________

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

When was your last eye examination?____
Do you have any eye conditions or problems? yes/no What kind?____________________________
Have you had any eye operations? yes/no Type_________________Date_____________
Have you had an eye injury? yes/no Kind______________________________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____________________
Additional Information____

Doctor Use Only
Reviewed by____ No changes____ Date____________________
Reviewed by____ No changes____ Date____________________
Reviewed by____ No changes____ Date____________________