Dr. Cindy W. Elrich, OD
4 Medical Drive
Chillicothe, Ohio 45601

VSP

PATIENT HISTORY QUESTIONNAIRE

(completion required at each patient appointment)

Please answer all questions.

Last name_____ First name_____ MI _____
Address_____ City_____ Zip _____
Telephone (W)_____ (H)_____
SSN ___-___-___-___ Date of birth_____
Occupation_____
Employer _____
Emergency contact/Telephone number _____
Date of last eye exam_____ Dilated?_____ Today's date_____
Where did you have your last eye exam?

Medical Information

What is your general health?_____

Do you have problems with any of these systems? *(please circle all that apply)*

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

Please explain _____
Diabetes? Y/N Type_____ Date of diagnosis _____
Allergies? Y/N Allergic to what?_____ What happens?_____
Medication allergy? Y/N What happens? _____ Headaches? Y/N
Other health problems _____
Current medication(s)_____
Have you had any operations? Y/N Kind?_____ When?_____
Do you use cigarettes/tobacco?_____ Alcohol?_____ Other substance(s)? _____
Name of family doctor_____ Date of last visit _____
Date of last tetanus shot _____

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_____

Personal Eye Information

Other eye condition(s)? Y/N What kind?_____ Date_____
Have you had any eye operations? Y/N Type_____ Date_____
Have you had an eye injury? Y/N Kind_____ Date_____
Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred vision? Y/N
Other eye problems? Y/N What kind?_____
Do you wear glasses? Y/N Contact lenses? Y/N Type_____
Additional information_____
Whom may we thank for referring you?_____

Doctor's initials_____