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PATIENT HISTORY QUESTIONNAIRE

Last Name _____ First Name _____ MI _____
Street Address _____ City _____ ZIP _____
Home Telephone _____ Work Telephone _____
Social Security Number _____ - _____ - _____ Date of Birth _____ Age _____
Occupation _____ Employer _____
Significant Other's Name (if applicable) _____
Insurance Information _____
Emergency Contact _____ Emergency Contact Telephone _____
Date of Last Eye Exam _____ Dilated? _____ Today's Date _____

MEDICAL INFORMATION

What is your general health? _____

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

Gastrointestinal	Nervous	Eyes	Ears/Nose/Throat
Cardiovascular	Genitourinary	Endocrine	Integumentary(skin)
Musculoskeletal	Blood/Lymph	Respiratory	Allergic/Immunologic

Please explain the problem(s) _____

Please answer all that apply:

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 smoke? _____ Drink Alcohol? _____ Use "Other Substances"? _____

Name of Family Doctor _____ Date of Last Visit _____

FAMILY HISTORY

Does anyone in your family have any of the following health problems?(please circle all that apply)

High Blood Pressure	Relation _____	Macular Degeneration	Relation _____
Diabetes	Relation _____	Retinal Detachment	Relation _____
Glaucoma	Relation _____	Cataracts	Relation _____

Other eye condition(s)? _____ If so, what kind? _____

PERSONAL EYE INFORMATION

Have you had any eye operations? Y/N Type _____ Date _____

Have you had an eye injury? Y/N Type _____ 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 _____

Whom may we thank for referring you? _____