Dr. Rick J. Unsell, LLC
PATIENT HISTORY QUESTIONNAIRE

Last Name ______________________First Name ____________________ MI _____
Date of Birth __________ Home Phone ____________ Work Phone ____________
Emergency Contact Name ____________________ Phone Number ______________
Date of Last Eye Exam ________Dilated? Yes/No Referred By _______________

MEDICAL INFORMATION

Do you have problems with any of these systems? (Please circle yes or no.)

Gastrointestinal	**Yes/No**	**Nervous**	**Yes/No**	**Endocrine**	**Yes/No**
Ears/Nose/Throat	**Yes/No**	**Urinary**	**Yes/No**	**Blood/Lymph**	**Yes/No**
Cardiovascular	**Yes/No**	**Muscles/Bones**	**Yes/No**	**Allergies**	**Yes/No**
Respiratory	**Yes/No**	**Skin**	**Yes/No**	**Headaches**	**Yes/No**
High Blood Pressure	**Yes/No**	**Mental**	**Yes/No**		

Please explain: ____
Diabetes: Yes/No Type ________________ Date of Diagnosis ___________

Please list medications to which you are allergic: _____________________________

Please list current medications: ____
____

Please list any hospitalizations and/or operations: ____________________________
____

Name of family doctor: ____

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

Do you have any eye conditions or problems? Yes/No What kind? ______________
Have you had any eye operations? Yes/No Type and Date ______________________
Have you had an eye injury? Yes/No Type and Date _________________________

Do you have glaucoma?	**Yes/No**	**Cataracts?**	**Yes/No**
Macular degeneration?	**Yes/No**	**Retinal Detachment**	**Yes/No**
Blurred vision?	**Yes/No**	**Dry eyes?**	**Yes/No**
Do you wear glasses?	**Yes/No**	**Contact Lenses**	**Yes/No**

DOCTOR USE ONLY

Reviewed by _____ No changes _____ Date _____ Reviewed by _____ No changes _____ Date _____
Reviewed by _____ No changes _____ Date _____ Reviewed by _____ No changes _____ Date _____