Keith Kosakura, O.D.

Patient History Questionnaire

Name (Dr./ Mr./ Mrs./ Ms.)_____

Address_____City_____State_____Zip_____

Home #_____Work #_____

Cell #_____OK to text? Yes/No Email_____

DOB_____Occupation_____Employer_____

Emergency Contact Name_____ Phone Number_____

Vision Insurance Carrier_____SSN/Insurance ID_____

Medical Insurance Carrier_____Insurance ID_____

Date of Last Eye Exam_____Dilated? Yes/No

Today's Date_____Referred by_____

Medical Information

How is your general health?_____

Height_____Weight_____

Smoking Status: never / former / Current (how much? How long?)_____

Current Medicines_____check if none ☐

_____

Allergies to Medications? Yes / No Which?_____Reactions _____

_____

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	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please Explain _____

Diabetes? Yes / No Type_____Date of Diagnosis_____

Other Health Problems_____

Have you had any operations? Yes / No Kind_____When?_____

Name of Family Doctor_____Date of last visit_____

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_____Date_____

Have you had an eye injury? Yes/No Type_____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 of Contacts?	_____

Additional Information_____