Patient History Questionnaire

Full Name:_____ Miss. Mrs. Ms. Mr. Dr. Rev.

Address:_____ Single Married Divorced Separated Widowed

City: _____ ST: _____ ZIP: _____ Birthdate: _____/_____/_____

Email Address: _____ Social Security #: _____-_____-_____

Occupation: _____ Home Phone: _____

Employer:_____ Cell Phone: _____

Medical Doctor: _____ Work Phone: _____

Previous Eye Doctor:_____ Last Exam: _____/_____/_____

Medical Insurance:_____ Last Eye Exam:_____/_____/_____

Communication preference: Please Circle Postal Phone Email Text Vision Inurance: _____

OCULAR HISTORY Please Cirlce

Do you wear glasses? NO YES If yes, how old is your present pair of lenses? _____

Do you wear Contacts? NO YES If yes, What type? Rigid Soft Toric Mulitfocal Monovision Extended Wear

Do you wear them Full Time Part Time How frequently do you replace them? _____

Have you had refractive surgery? NO YES If yes, Date ____/____/_____ Type: _____

What other services would you like to be evaluated for? Refractive Surgery Contact Lens Glasses

What are you being seen for today? _____

Are you currently experiencing any of the following problems with your eyes? Please Circle

Blurred Vision	Flashes/Floaters	Redness
Loss Of Vision	Halos/Glare/Light Sensitivity	Excess Tearing/Watering
Loss Of Side Vision	Dryness	Eye Pain or Soreness
Distorted Vision	Sandy or Gritty Feeling	Mucous Discharge
Double vision	Burning	Inflammation of the Eyelid
Tired Eyes	Itching	Styes or Chalazion

Have you been diagnosed with any of the following ocular problems? Please Circle

Cataracts	Glaucoma	Retinal Detachment/Disease
Crossed Eyes	Lazy Eye/Amblyopia	Dry Eye
Eye Injury	Macular Degeneration	Other: _____

SOCIAL HISTORY This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Please Circle

Do you drive? NO YES If yes, do you have visual difficulty when driving? NO YES

Please describe the difficulty you have while driving: _____

Do you use tobacco products? NO YES If yes, type/amount/how long: _____

Do you drink alcohol? NO YES If yes, type/amount/how long: _____

Do you use illegal drugs? NO YES If yes, type/amount/how long:_____

Have you ever been exposed to or infected with Gonorrhea Hepatitis HIV Syphilis

*PLEASE SEE REVERSE SIDE

MEDICAL HISTORY Please Circle

List any medications you are currently taking (include any contraceptives, aspirin, over the counter medications):

_____

_____

Are you allergic to any medications? NO YES If yes, Which ones: _____

List all major surgeries and/or hospitalizations you have had:

_____

_____

REVIEW OF SYSTEMS Please circle the item that you are currently having or have had in the follow areas:

Allergic/Immunologic
- Allergy/Hay Fever

Cardiovascular/Cardiac
- Arteriosclerosis
- Heart Disease
- High Blood Pressure
- High Cholesterol

Constitutional
- Fever
- Weight Loss/Gain

Ears, Nose, Mouth, Throat
- Sinus Congestion
- Dry Throat/Mouth

Endocrine
- Diabetes
- Thyroid Disease
- Chronic Fatigue

Gastrointestinal
- Diarrhea/Constipation
- IBS/Chron's Disease
- Ulcers
- Reflux

Genitourinary
- Kidney Disease
- Ovarian/Uterine Cancer
- Prostate Cancer

Hematologic/Lymphatic
- Anemia
- Bleeding Problems
- Breast Cancer

Integumentary
- Cancer
- Rashes
- Easy Bruising

Musculoskeletal
- Rheumatoid Arthritis
- Muscle Pain
- Joint Pain

Neurological
- Migraines
- Dizziness
- Seizures
- Stroke

Psychiatric
- Anxiety
- Depression
- Memory Loss
- Hallucinations

Respiratory
- Asthma
- Bronchitis
- Emphysema
- Chronic Cough

If you have circled any of the boxes above or have a condition not listed, please explain further:

_____

_____

Are you pregnant or nursing? NO YES

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased, **please note whether paternal or maternal**)

	Relation To You		Relation To You
Glaucoma	_____	Diabetes	_____
Cataract	_____	Cancer	_____
Macular Degeneration	_____	Heart Disease	_____
Retinal Detachment	_____	High Blood Pressure	_____
Blindness	_____	Kidney Disease	_____
Cross Eyes	_____	Lupus/Arthritis	_____

Signature: _____ Date: _____/_____/_____