

Patient History Questionnaire

Date: _____

Name: _____ **First:** _____ **Initial** _____ **Nickname:** _____ **Home:** _____

Address: _____ **Date of Birth** _____ **Work:** _____

_____ **Gender:** _____ **SSN:** _____ **Cell:** _____

City: _____ **State:** _____ **Zip** _____ **Parent / Guardian** _____

E-Mail _____ **Family Doctor** _____ **Dr Phone** _____

Occupation _____ **Computer Usage** _____

Special _____ **Hobbies /** _____

Needs _____ **Sports** _____

Last Eye Exam _____ **Alt. Contact** _____ **Primary** _____

Last Medical Exam _____ **Relationship** _____ **Alternate** _____

Note: For dates where exact date is unknown. Please use a number that is as close as you can remember.

Note to Patient: Only check those items you are experiencing or think you might be. You don't have to click the No

Review of Systems

Do you currently or have you ever had any problems in the following areas:

CONSTITUTIONAL

Fever _____ Yes _____ No _____ ?
 Weight Gain/Loss _____ Yes _____ No _____ ?

INTEGUMENTARY

Skin _____ Yes _____ No _____ ?

NEUROLOGICAL

Headaches _____ Yes _____ No _____ ?
 Migraines _____ Yes _____ No _____ ?
 Seizures _____ Yes _____ No _____ ?

EYES

Loss of Vision _____ Yes _____ No _____ ?
 Blurred Vision _____ Yes _____ No _____ ?
 Distored Vision/Halos _____ Yes _____ No _____ ?
 Loss of Side Vision _____ Yes _____ No _____ ?
 Double Vision _____ Yes _____ No _____ ?
 Dryness _____ Yes _____ No _____ ?
 Mucous Discharge _____ Yes _____ No _____ ?
 Redness _____ Yes _____ No _____ ?
 Itching _____ Yes _____ No _____ ?
 Burning _____ Yes _____ No _____ ?
 Foreign Body Sensation _____ Yes _____ No _____ ?
 Excess Tearing _____ Yes _____ No _____ ?
 Glare / Light Sensitivity _____ Yes _____ No _____ ?
 Eye Pain or Soreness _____ Yes _____ No _____ ?
 Chronic Infection of Eye or Lid _____ Yes _____ No _____ ?
 Styes or Chalazion _____ Yes _____ No _____ ?
 Flashers _____ Yes _____ No _____ ?
 Floaters in Vision _____ Yes _____ No _____ ?
 Tired eyes _____ Yes _____ No _____ ?

RESPIRATORY

Asthma _____ Yes _____ No _____ ?
 Chronic Bronchitis _____ Yes _____ No _____ ?
 Emphysema _____ Yes _____ No _____ ?
 Sleep Apnea _____ Yes _____ No _____ ?

EARS, NOSE THROAT AND MOUTH

Allergies / Hay Fever _____ Yes _____ No _____ ?
 Sinus Congestion _____ Yes _____ No _____ ?
 Runny Nose _____ Yes _____ No _____ ?
 Post-Nasal Drip _____ Yes _____ No _____ ?
 Chronic Cough _____ Yes _____ No _____ ?
 Dry Throat / Mouth _____ Yes _____ No _____ ?
 Ringing In Ears _____ Yes _____ No _____ ?
 Ear Pain or Infection _____ Yes _____ No _____ ?
 Hearing Aids _____ Yes _____ No _____ ?
 Deaf _____ Yes _____ No _____ ?

VASCULAR, CARDIOVASCULAR

Diabetes _____ Yes _____ No _____ ?
 Heart Disease _____ Yes _____ No _____ ?
 High Blood Pressure _____ Yes _____ No _____ ?
 High Cholesterol _____ Yes _____ No _____ ?

GASTROINTESTINAL

Diarrhea _____ Yes _____ No _____ ?
 Constipation _____ Yes _____ No _____ ?

GENITOURINARY

Gonads / Kidneys / Bladder _____ Yes _____ No _____ ?

BONES / JOINTS / MUSCLES

Rheumatoid Arthritis _____ Yes _____ No _____ ?
 Muscle Pain _____ Yes _____ No _____ ?
 Joint Pain _____ Yes _____ No _____ ?

LYMPHATIC / HEMATOLOGICAL

Anemia _____ Yes _____ No _____ ?
 Bleeding Problems _____ Yes _____ No _____ ?

ENDOCRINE

Thyroid / Other Glands _____ Yes _____ No _____ ?

ALLERGIC, IMMUNOLOGIC

_____ Yes _____ No _____ ?

PSYCHIATRIC

_____ Yes _____ No _____ ?

If you answered " ? " to any of the above or have a condition not listed, please explain.

Family History

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions

DISEASE/CONDITION				RELATIONSHIP
Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Cataract	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Crossed Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Macular Degeneration	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Retinal Detachment / Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____

If Other, explain _____

Medical History

Do you have any allergies To Medications? Yes No

If Yes, Explain _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies)

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

List Any of the following that you have had:

Prominent Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Crossed Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lazy eye	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drooping Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Are you pregnant? Yes No

Do you wear glasses Yes No If yes, how old is your present pair of lenses? _____ Years

Do you wear contacts? Yes No If yes, how old is your present pair of lenses? _____ Weeks

Type of Contact Lenses: Rigid Soft Extended Wear Other Are they comfortable? Yes No

Social History

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

Yes No I WOULD PREFER TO DISCUSS MY SOCIAL HISTORY INFORMATION DIRECTLY WITH MY DOCTOR.

Do You Drive? Yes No If yes, do you have any visual difficulty when driving? Yes No

If yes, please describe _____

Do You use:

tobacco products? Yes No If yes, type / amount / how long? _____

alcohol? Yes No If yes, type / amount / how long? _____

illegal drugs? Yes No If yes, type / amount / how long? _____

Have you ever been exposed to or infected with:

Gonorrhea Yes No ? Hepatitis Yes No ?

Syphilis Yes No ? HIV / AIDS Yes No ?