Patient History Questionnaire

Last: First: Preferred Name: Home phone:
Address: Date of Birth:
____ SSN:_____________ Cell phone:
City: State: Zip: Email:____________________
Last Eye Exam: Primary Care Physician:
Physician Phone Number:

Note to Patient: **Only check those items you are experiencing** or think you might be.
Do you currently or have you ever had any problems in the following areas:

SKIN __Yes __No __?

EYES

Headaches	__Yes	__No	__?
Migraines	__Yes	__No	__?
Seizures	__Yes	__No	__?
Loss of Vision	__Yes	__No	__?
Blurred vision	__Yes	__No	__?
Distorted vision/halos	__Yes	__No	__?
Loss of side vision	__Yes	__No	__?
Double vision	__Yes	__No	__?
Dryness	__Yes	__No	__?
Redness	__Yes	__No	__?
Itching	__Yes	__No	__?
Burning	__Yes	__No	__?
Foreign body sensation	__Yes	__No	__?
Styes	__Yes	__No	__?
Flashes/Floaters	__Yes	__No	__?
Tired eyes	__Yes	__No	__?
Color blind	__Yes	__No	__?

RESPIRATORY

Asthma	__Yes	__No	__?
Sleep Apnea	__Yes	__No	__?
Emphysema	__Yes	__No	__?
ALLERGIES	__Yes	__No	__?

CARDIOVASCULAR

Heart Disease	__Yes	__No	__?
High Blood Pressure	__Yes	__No	__?
High cholesterol	__Yes	__No	__?

BONES, JOINTS, MUSCLES

Rheumatoid Arthritis	__Yes	__No	__?

ENDOCRINE

Thyroid	__Yes	__No	__?
Diabetes	__Yes	__No	__?

Other important health issues:______________
____

MEDICAL HISTORY

Do you have any allergies to medications? __Yes __No __? If YES, explain:________________________

MEDICINE Please list any medications you are taking: Seasonal Allergy Medicine

Are you pregnant?	__Yes	__No	__?
Do you wear glasses?	__Yes	__No	__?
Do you wear contacts?	__Yes	__No	__?

Are they comfortable? __Yes __No __?

FAMILY HISTORY - Please note only parents, siblings, and children

				RELATIONSHIP
Blindness	__Yes	__No	__?	________________
Glaucoma	__Yes	__No	__?	________________
Crossed Eyes	__Yes	__No	__?	________________
Macular degeneration	__Yes	__No	__?	________________
Retinal detachment	__Yes	__No	__?	________________
Heart Disease	__Yes	__No	__?	________________

Other important family health history: ____
____

Do you use alcohol:	__Yes	__No	__?
Tobacco products:	__Yes	__No	__?
HIV:	__Yes	__No	__