

Patient History Questionnaire

Date: _____

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

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

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

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

EMail _____ **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 _____

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 _____
 Tired eyes _____ Yes _____ No _____ ?

RESPIRATORY

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

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 _____
 Ear Pain or Infection _____
 Hearing Aids _____
 Deaf _____

VASCULAR, CARDIOVASCULAR

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

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

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	Yes	No	?	RELATIONSHIP
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment / Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No						
Do you wear glasses	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how old is your present pair of lenses?	_____	Years			
Do you wear contacts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how old is your present pair of lenses?	_____	Weeks			
Type of Contact Lenses:	<input type="checkbox"/> Rigid	<input type="checkbox"/> Soft	<input type="checkbox"/> Extended Wear	<input type="checkbox"/> Other	Are they comfortable?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 ?