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 Needs _____ **Hobbies / 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				RELATIONSHIP
Blindness	___ Yes	___ No	___ ?	
Cataract	___ Yes	___ No	___ ?	
Glaucoma	___ Yes	___ No	___ ?	
Crossed Eyes	___ Yes	___ No	___ ?	
Macular Degeneration	___ Yes	___ No	___ ?	
Retinal Detachment / Disease	___ Yes	___ No	___ ?	
Arthritis	___ Yes	___ No	___ ?	
Cancer	___ Yes	___ No	___ ?	
Diabetes	___ Yes	___ No	___ ?	
Heart Disease	___ Yes	___ No	___ ?	
High Blood Pressure	___ Yes	___ No	___ ?	
High Cholesterol	___ Yes	___ No	___ ?	
Kidney Disease	___ Yes	___ No	___ ?	
Lupus	___ Yes	___ No	___ ?	
Thyroid Disease	___ Yes	___ No	___ ?	
Other	___ Yes	___ No	___ ?	

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, asprin, 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	___ Yes	___ No	Crossed Eyes	___ Yes	___ No	Lazy eye	___ Yes	___ No
Eye Infection	___ Yes	___ No	Retinal Disease	___ Yes	___ No	Glaucoma	___ Yes	___ No
Cataracts	___ Yes	___ No	Eye Injury	___ Yes	___ No	Drooping Eyes	___ Yes	___ 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 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 beeen exposed to or infected with:

Gonnorhea ___ Yes ___ No ___ ? Hepatitis ___ Yes ___ No ___ ?

Syphlilis ___ Yes ___ No ___ ? HIV / AIDS ___ Yes ___ No ___ ?