Patient History Questionnaire

Date:

Last: ______ **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 ___ 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 ___ ?
- Color blind ___ Yes ___ No ___ ?

RESPIRATORY

- Asthma ___ Yes ___ No ___ ?
- Chronic Bronchitis ___ Yes ___ No ___ ?
- Emphysema ___ Yes ___ No ___ ?
- Sleep Apnea ___ Yes ___ No ___ ?

EARS, NOSE AND THROAT

- 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.

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

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 ______

Social History

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

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 ___ ?