

PATIENT HISTORY QUESTIONNAIRE

Please answer all questions.

Name: _____ Today's Date: ____/____/____
Address: _____ Home Phone: _____
City: _____ State: ____ Zip: _____ Cell Phone: _____
Guardian (if patient is under 18): _____ Work Phone: _____
Birth Date: ____/____/____ SSN: ____/____/____ Occupation: _____
Name of Medical Doctor: _____ Last Medical Exam: ____/____/____
Last Eye Exam: ____/____/____

Medical / Ocular 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, vitamins, etc):

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

List any eye diseases, infections, injuries or conditions that you have or have had: _____

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

Do you wear contact lenses? yes no If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid/Hard Soft Brand: _____ Are they comfortable? yes no

Do you want to have your (or this patient's) eyes dilated at the exam today?: yes no

Family History

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

Disease/Condition	Yes	No	Unknown	Disease/Condition	Yes	No	Unknown
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid 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"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History *This information is kept strictly confidential.*

Do you drive? yes no If so, do you have visual difficulty when driving (day or night)? yes no If yes, describe:

Are you pregnant or breast feeding? yes no If pregnant, how far along: _____

Do you use tobacco products? yes no If yes, type / amount / how long: _____

Do you drink alcohol? yes no If yes, type / amount / how long: _____

Do you use illegal drugs? yes no If yes, type / amount / how long: _____

Have you even been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis Herpes

Review of Systems

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

SYSTEM	YES	NO	UNKNOWN	SYSTEM	YES	NO	UNKNOWN
INTEGMENTARY (SKIN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EAR/NOSE/THROAT			
NEUROLOGICAL				Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY			
EYES				Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CARDIOVASCULAR			
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE			
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching/Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy/Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of Diabetes: _____			
Excess Tearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of Diagnosis: _____			
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Last Sugar Reading and Date: _____			
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Sties/Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

If you answered YES to any of the above or have a condition not listed, please explain and list all medications: _____

Patient/Guardian Signature: _____ Date: _____

FOR OFFICE STAFF ONLY

I have reviewed the history with the patient and made changes if necessary: _____ Date: _____

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