Patient History Questionnaire

Today's Date: _____

Last Name: _____ First Name: _____ Home Phone#_____

Address: _____ DOB_____Work#_____

City: _____ State: _____ Zip Code_____ Cell#_____

Email _____ Gender_____ SSN: _____

Occupation _____ Parent/Guardian _____

Special Needs _____ Computer Usage/ Hobbies_____

Family Doctor's Name _____ Dr's Phone # _____ Fax # _____

Last Eye Exam_____ Last Medical Exam _____

Alt.Contact _____Relationship _____Phone #_____

NOTE: For dates where exact date is unknown. Please use closest date as remembered.

Do you currently or have you ever had any of the following medical issues

Constitutional				***Ears, Nose, Throat and Mouth***			
Fever	Yes	No	?	Allergies/Hay Fever	Yes	No	?
Weight Gain/Loss	Yes	No	?	Sinus Congestion	Yes	No	?
Integumentary				Runny Nose	Yes	No	?
Skin	Yes	No	?	Post Nasal Drip	Yes	No	?
Neurological				Chronic Cough	Yes	No	?
Headaches	Yes	No	?	Dry Throat/Mouth	Yes	No	?
Migraines	Yes	No	?	Ringing in Ears	Yes	No	?
Seizures	Yes	No	?	Ear Pain or Infection	Yes	No	?
Eyes				Hearing aid	Yes	No	?
Loss of Vision	Yes	No	?	Deaf	Yes	No	?
Blurred Vision	Yes	No	?	***Vascular, Cardiovascular***			
Distorted Vision	Yes	No	?	Diabetes	Yes	No	?
Loss of side Vision	Yes	No	?	Heart Disease	Yes	No	?
Double Vision	Yes	No	?	High Blood Pressure	Yes	No	?
Dryness	Yes	No	?	High Cholesterol	Yes	No	?
Mucous Discharge	Yes	No	?	***Gastrointestinal***			
Redness	Yes	No	?	Diarrhea	Yes	No	?
Itching	Yes	No	?	Constipation	Yes	No	?
Burning	Yes	No	?	***Genitourinary***			
Foreign Body Sen.	Yes	No	?	Gonads/Kidneys/Bladder	Yes	No	?
Excess Tearing	Yes	No	?	***Bones/Joints/Muscles***			
Glare/Light Sensit.	Yes	No	?	Rheumatoid arthritis	Yes	No	**?**
Eye Pain	Yes	No	?	Muscle Pain	Yes	No	?
Chronic Infect. Eye	Yes	No	?	Joint Pain	Yes	No	?

Style or Chalazion	Yes	No	?	***Lymphatic/Hematological***			
Flashers	Yes	No	?	Anemia	Yes	No	?
Floaters in Vision	Yes	No	?	Bleeding Problems	Yes	No	?
Tired eyes	Yes	No	?	***Endocrine***			
Respiratory				Thyroid/Other Glands	Yes	No	?
Asthma	Yes	No	?	***Allergic, Immun.***	Yes	No	?
Chronic Bronchitis	Yes	No	?	***Psychiatric***	Yes	No	?
Emphysema	Yes	No	?				
Sleep Apnea	Yes	No	?				

Medical History

Do you have any allergies to medications Yes No

If yes, please explain _____

List all medications your currently are taking

_____

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

_____

Circle any of the following conditions you have had

Prominent	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	Yes	No	Drooping Eye	Yes	No
Are you pregnant	Yes	No						
Do you wear glasses	Yes	No	If yes, how old is your present RX? _____ Years					
Do you wear contacts	Yes	No	If yes, how old is your present RX? _____ Years					
Type of Contact Lenses		Rigid	Soft	Extended wear	other	Are they comfortable	Yes	No

Family History

Blindness	Yes	No	?	Relationship _____
Cataract	Yes	No	?	Relationship _____
Glaucoma	Yes	No	?	Relationship _____
Crossed Eyes	Yes	No	?	Relationship _____
Macular Degen.	Yes	No	?	Relationship _____
Retinal Detach.	Yes	No	?	Relationship _____
Arthritis	Yes	No	?	Relationship _____
Cancer	Yes	No	?	Relationship _____
Diabetes	Yes	No	?	Relationship _____
Heart Disease	Yes	No	?	Relationship _____
High Blood Press.	Yes	No	?	Relationship _____
High Cholesterol	Yes	No	?	Relationship _____
Kidney Disease	Yes	No	?	Relationship _____
Lupus	Yes	No	?	Relationship _____
Thyroid Disease	Yes	No	?	Relationship _____
Other	Yes	No	?	Relationship _____

Social History

This information is kept strictly confidential. If you prefer you can discuss this section of the questionnaire directly with the doctor privately.

Yes I would prefer to speak to the Doctor privately.

Do you drive Yes No If yes, do you have any visual difficulty when driving?

If yes, please describe _____

Do you use:

Tobacco prods. 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 any of these illnesses?

Gonorrhea	Yes	No	?	Hepatitis	Yes	No	?
Syphilis	Yes	No	?	HIV/AIDS	Yes	No	?

Signature: _____ Date: _____