Patient History Questionnaire

Today S Date.				
Last Name:	First Name:		_ Home Phone#	
Address:	DC	DB	Work#	
City:	State:	Zip Code	Cell#	
Email	Gender		SSN:	
Occupation	Parent/Guard	ian		
Special Needs	Comp	uter 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		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	?

Placeters Ves	Style or Chalazion	Yes	No	?		Lymph	atic/Hem	atological			
Time deves	Flashers	Yes	No	?		Anemia	Anemia Yes		s No	?	
Thyroid/Other Glands	Floaters in Vision	Yes	No	?		Bleeding Problems		Yes	s No	?	
Authma	Tired eyes	Yes	No	?		Endocr	ine				
Chronic Branchists	Respiratory					Thyroid	Other Gla	nds Yes	s No	?	
Chronic Branchists	Asthma	Yes	No	?		Allergi	c, Immun.	Yes	s No	?	
Medical History	Chronic Bronchitis	Yes	No	?					s No	?	
Medical History Medical Hi						.,					
Do you have any allergies to medications											
Do you have any altergites 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 List all major injuries, surgeries and /or hospitalizations you have had 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 Seye infection Yes No Retinal Disease Yes No Gilaucoma Yes No Cataracts Yes No Betinal Disease 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?						Medical H	listorv				
List all medications your currently are taking Circle any of the following conditions you have had Circle any of the following conditions your bave had Circle any of the following conditions your bave had Circle any of the following conditions your bave had Circle any of the following conditions your bave had Circle any of the following conditions your bave had Circle any of the following conditions your bave had Circle any of the following conditions your bave had Lazy Eve Yes No Claucoma Yes No If yes, how old is your present RX? Years Vears Vears No Powers Family History Bilindness Yes No Relationship Family History Bilindness Yes No Relationship Circle any of the following conditions your bave had Circle any Eve Yes No Relationship Family History Family History No Family History No Family History No Family History No Powers No Po	Do you have any alle	rgies to m	nedications		Yes No	····ca··ca····	15101 y				
List all maglor injuries, surgeries and /or hospitalizations you have had		_	realcations		165 140						
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 Eye Injury Yes 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? Do you wear contacts Yes No If yes, how old is your present RX? Type of Contact Lenses Rigid Soft Extended wear other Are they comfortable Yes No Family History Billindness Yes No ? Relationship Glaucoma Yes No ? Relationship Crossed Eyes Yes No ? Relationship Retinal Detach. Yes No ? Relationship Retinal Detach Yes No ? Relationship			our curre	ently are	takina						
Circle any of the following conditions you have had Prominent Yes No Crossed Eyes Yes No Lazy Eye Yes No No Eye infection Yes No Retinal Disease Yes No Glaucoma Yes No No Yes Yes No Drooping Eye Yes No No No Yes Yes No Drooping Eye Yes No No No Yes Yes No No No No No No No N	List an incarea	cions y	Jui cuire	intry urc	tuning						
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 Lenser Rigid Soft Extended wear other Are they comfortable Yes No Family History Blindness Yes No ? Relationship Glaucoma Yes No ? Relationship Macular Degen. Yes No ? Relationship Macular Degen. Yes No ? Relationship Cancer Yes No ? Relationship Glaucoma Yes No ? Relationship Macular Degen. Yes No ? Relationship											
Prominent Yes No Crossed Eyes Yes No Lazy Eye Yes No	List all major injuries	s, surgerie	s and /or ho	ospitalizatio	ons you have had						
Prominent Yes No Crossed Eyes Yes No Lazy Eye Yes No											
Retinal Disease Yes No Glaucoma Yes No No Cataracts Yes No No No Drooping Eye Yes No No No No No No No N	Circle any of the	followi	ng condit	ions you	have had						
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?	Prominent	Yes	No		Crossed Eyes	Yes	No	Lazy Eye	Yes	No	
Are you pregnant Yes No	Eye infection	Yes	No		Retinal Disease	Yes	No	Glaucoma	Yes	No	
Do you wear glasses Yes No	Cataracts	Yes	No		Eye Injury Yes	Yes	No	Drooping Eye	Yes	No	
Tope of Contact Lenses Rigid Soft Extended wear other Are they comfortable Yes No Family History Blindness Yes No ? Relationship	Are you pregnant	Yes	No								
Type of Contact Lenses Rigid Soft Extended wear other Are they comfortable Yes No Family History Blindness Yes No ? Relationship	Do you wear glasses	Yes	No		If yes, how old is y	your present	RX?		Years		
Blindness Yes No ? Relationship	Do you wear contact	ts Yes	No		If yes, how old is y	your present	RX?		Years		
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 Lupus Yes No ? Relationship Thyroid Disease Yes No ? Relationship	Type of Contact Lens	ses	Rigid	Soft	Extended wear	other	Are the	y comfortable	Yes	No	
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 Lupus Yes No ? Relationship Thyroid Disease Yes No ? Relationship						Family Hi	story				
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	Blindness	Yes	No	?	Relationship						
Crossed Eyes Yes No ? Relationship	Cataract	Yes	No	?	Relationship						
Macular Degen. Yes No ? Relationship	Glaucoma	Yes	No	?	Relationship						
Retinal Detach. Yes No ? Relationship	Crossed Eyes	Yes	No	?	Relationship						
Arthritis Yes No ? Relationship	Macular Degen.	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	Retinal Detach.	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 Rel	Arthritis	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 Relationship High Cholesterol Yes No ? Relationship Heart Disease Yes No ? Relationship High Cholesterol Yes No ? Relationship Heart Disease Yes No ? Relationship High Cholesterol Yes No ? R	Cancer	Yes	No	?	Relationship						
High Blood Press. Yes No ? Relationship	Diabetes	Yes	No	?	Relationship						
High Cholesterol Yes No ? Relationship Kidney Disease Yes No ? Relationship Lupus Yes No ? Relationship Thyroid Disease Yes No ? Relationship	Heart Disease	Yes	No	?	Relationship						
Kidney Disease Yes No ? Relationship	High Blood Press.	Yes	No	?	Relationship						
Lupus Yes No ? Relationship Thyroid Disease Yes No ? Relationship	High Cholesterol	Yes	No	?	Relationship						
Thyroid Disease Yes No ? Relationship	Kidney Disease	Yes	No	?	Relationship						
	Lupus	Yes	No	?	Relationship						
Other Yes No ? Relationship	Thyroid Disease	Yes	No	?	Relationship						
	Other	Yes	No	?	Relationship						

Social History

This information is ke	pt strictly o	onfidential	. If you pre	fer you can discuss	this section o	of the quest	ionnaire directly with the doctor privately.		
	Yes	I would pr	ould prefer to speak to the Doctor privately.						
Do you drive	Yes	No	If yes, do you have any visual difficulty when driving?						
		If yes, plea	ease 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:				