# Patient History Questionnaire

**Date:** / /

**Name:** _____ **First:** _____ **Initial** ___ **Nickname:** _____ **Home:**

**Address:** _____ **Date of Birth** _____ **Work:** _____

_____ **Gender:** _____ **SSN:** ___-__-____ **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 | ___? |

### RESPIRATORY

| | | | |
|---|---|---|---|
| Asthma | ___Yes | ___No | ___? |
| Chronic Bronchitis | ___Yes | ___No | ___? |
| Emphysema | ___Yes | ___No | ___? |
| Sleep Apnea | ___Yes | ___No | ___? |

### 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 | ___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.

## 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 | ? |