PATIENT HISTORY QUESTIONNAIRE

Name: _____ **Today's Date:** _____ /_____ /_____

Address: _____ **City:** _____ **State:**_____ **Zip:** _____

Mobile Phone: _____ **Home Phone:** _____

Date of Birth: _____ /_____ /_____ **Social Security Number:** _____ - _____ - _____

Occupation: _____ **E-mail Address:** _____

Date of Last Eye Exam: _____ /_____ /_____

Name of Primary Doctor: _____ **Last Medical Exam:** _____ /_____ /_____

How Did You Hear About Us: _____

PERSONAL EYE INFORMATION:

Do you have any eye conditions (such as crossed eyes, lazy eye, glaucoma, retinal disease, cataracts)? YES / NO

If Yes, explain: _____

Do you have any of the following:	**Loss of vision**	**YES / NO**	**Blurred vision**	**YES / NO**
	Double vision	**YES / NO**	**Dryness**	**YES / NO**
	Excess tearing	**YES / NO**	**Glare/light sensitivity**	**YES / NO**
	Styes/chalazion	**YES / NO**	**Flashes/floaters**	**YES / NO**

Have you had any eye operations? YES / NO Type: _____ **Date:** _____

Have you had an eye injury? YES / NO Type: _____ **Date:** _____

Do you wear glasses? YES / NO

Do you wear contact lenses? YES / NO Type: [ ] Rigid [ ] Soft [ ] Other Brand: _____

SOCIAL HISTORY:

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: _____

Have you ever been exposed or infected with any sexually transmitted diseases? YES / NO

Have you ever had a blood transfusion? YES / NO

*****Please turn this form over and complete side two*****

MEDICAL INFORMATION:

Do you take medications for any of these systems?

Allergy	**YES / NO**	**Cardiovascular**	**YES / NO**	**Endocrine**	**YES / NO**
Gastrointestinal	**YES / NO**	**Genitourinary**	**YES / NO**	**Ears/Nose/Throat**	**YES / NO**
Blood/Lymph	**YES / NO**	**Immunologic**	**YES / NO**	**Integumentary (Skin)**	**YES / NO**
Musculoskeletal	**YES / NO**	**Neurological**	**YES / NO**	**Psychiatric**	**YES / NO**
Respiratory	**YES / NO**				

Are you diabetic? YES / NO Type:_____ Date of diagnosis: _____ /_____ /_____

If you answered YES to any of the above or have a condition not listed, please explain:

_____

_____

List any medications that you currently take (including oral contraceptives and over the counter medications):

_____

_____

_____

_____

Do you have any allergies to medications? YES / NO If yes, explain: _____

Are you pregnant and or nursing? YES / NO

List all major operations/hospitalizations you have had: _____

FAMILY HISTORY:

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

High Blood Pressure	**YES / NO Relation _____**		**Diabetes**	**YES / NO Relation _____**	
Arthritis	**YES / NO Relation _____**		**Thyroid**	**YES / NO Relation _____**	
Kidney	**YES / NO Relation _____**		**Lupus**	**YES / NO Relation _____**	
Retinal Detachment	**YES / NO Relation _____**		**Glaucoma**	**YES / NO Relation _____**	
Macular Degeneration	**YES / NO Relation _____**		**Cataracts**	**YES / NO Relation _____**	
Crossed Eyes	**YES / NO Relation _____**				

DOCTOR USE ONLY:

Reviewed by: _____ [ ] No changes Date: _____ /_____ /_____

Reviewed by: _____ [ ] No changes Date: _____ /_____ /_____

Reviewed by: _____ [ ] No changes Date: _____ /_____ /_____