PATIENT HISTORY QUESTIONAIRE

DATE: _____/_____/_____ **Patient SS #** _ _ _ - _ _ - _ _ _ _

Last Name:______________________ First Name: _____________________ MI:_____ Nickname:___________
Address: ____
Telephone: (Home) ___________________ (Cell) ____________________ (Work) ________________________
E-mail : ____
Sex: M F Date of Birth: _____/_____/_____ Married Single Other ___________________
Employer:_________________________________ Occupation:____
Primary Care Physician:_____________________ Date Last Medical Exam:______________________________
Previous Eye Doctor: _______________________ Date Last Eye Exam:__________________________________

Medical Insurance:_____________________ Medical Insurance ID # ________________ Group # __________
Vision Insurance:_______________________ Vision Insurance ID # ______________________________

Responsible Party (If same as above check here and go to next section. _____)
Name:_____________________________________ SSN: ______/______/______ Birthdate:_____/_____/_____
Address:____Phone:___________________
Relationship to Patient:____________________ Spouse's Name (if Married):____________________________

MEDICAL INFORMATION

Do you have any **allergies to medications?** Yes ___ No ___ If "Yes" List:_____________________________
Other Allergies? Yes ___ No ___ If "Yes" List:____

List any **medications you are currently taking and the reason you take them if known.** (Include oral contraceptives, aspirin, over the counter meds, and home remedies.)

____

____

List all major surgeries, injuries, and/or hospitalizations you have had. (Give approximate dates) ____________

____

____

____

PERSONAL EYE HISTORY

Have you had any **eye surgery?** Yes ____ No ____ If yes explain:______________________________________
Have you had any **eye injuries?** Yes ____ No ____ If yes explain:______________________________________
Do you wear glasses? Yes ___ No ___ If yes, how old are your current lenses? __________________________
Do you wear contact lenses? Yes ___ No ___ Disposable Or Gas Perm?_________________________________
If disposable, what brand? ____

FAMILY HISTORY (Include parents, children, siblings, grandparents – living or deceased)

CONDITION		RELATIONSHIP TO YOU **(Include Paternal or Maternal for Grandparents)**	CONDITION		RELATIONSHIP TO YOU
Blindness	Yes No	______________________	Macular Degeneration	Yes No	____________________
Cataract	Yes No	______________________	Retinal Detachment	Yes No	____________________
Crossed Eyes	Yes No	______________________	Cancer	Yes No	____________________
Glaucoma	Yes No	______________________	Diabetes Type?	Yes No	____________________

OVER

REVIEW OF SYSTEMS: Please circle any of the following conditions that apply to you:

CONSTITUTION:
- Fever
- Malaise
- Weight Loss
- Weight Gain

INTEGUMENTARY:
- Skin Lesions
- Acne
- Adult Acne
- Rash
- Psoriasis
- Edema
- Eczema
- Skin Cancer
- Rosacea
- Other:

EYES:
- Shingles Affecting Eye
- Styes/Chalazion
- Double Vision
- Lazy Eye: Right or Left?
- Blurred Vision
- Blepharitis
- Cataracts
- Corneal Dystrophy
- Diabetic Retinopathy
- Distorted Vision
- Dry Eyes
- Tearing
- Fatique/Asthenopia
- Flashes
- Floaters
- Glaucoma
- Ocular Hypertension
- Herpes Simplex
- Legally Blind
- Light Sensitivity
- Loss of Vision
- Macular Degeneration
- Peripheal Loss of Vision
- Droopy Lids: Right or Left?

CANCER:
- What Type?
- When Diagnosed?
- Treatment?

NEUROLOGICAL:
- Alzheimers
- Epilepsy
- Migraine Headaches
- Multiple Sclerosis
- Myasthenia Gravis
- Parkinson's Disease
- Other:

ENDROCRINE:
- Diabetes Type:___________
- Insulin Dependent
- Non Insulin Dependent
- When Diagnosed?
- How Treated? Oral Meds, Injection, Diet
- Kidney Disease
- Acute Renal Failure
- Polycystic Kidney Disease
- On Dialysis:
- ___ X per Week Done at Treatment Center or Home Dialysis
- Kidney Transplant Candidate
- Thyroid Disease: Hypo or Hyper
- Pituitary Gland Dysfunction
- Adrenal Gland Dysfunction
- Other:

EARS, NOSE, MOUTH, THROAT:
- Allergies/Hay Fever
- Hearing Aids
- Sinus Congestion
- Runny Nose
- Post-Nasal Drip
- Chronic Cough
- Dry Throat/Mouth
- Other:

RESPIRATORY:
- Asthma
- Chronic Bronchitis
- Emphysema
- Other:

GASTROINTESTINAL:
- Acid Reflux
- Diarrhea
- Hiatal Hernia
- Other:

VASCULAR/CARDIOVASCULAR:
- Elevated Cholesterol
- High Blood Pressure
- Congestive Heart Disease
- Vascular Disease
- Other:

GENITOURINARY:
- Kidney Failure
- Bladder
- STD
- Prostate
- Pregnancy
- Nursing

MUSCULOSKELETAL:
- Ankylising Spondylitis
- Arthritis
- Joint Pain
- Juvenile Rheumatoid Arthritis
- Muscle Pain Other
- Myasthenia Gravis
- Osteoarthritis
- Osteoporosis
- Rheumatoid Arthritis
- Other:

LYMPHATIC/HEMATOLOGIC:
- Anemia
- Bleeding Problems
- Lymphadenopathy
- Other:

IMMUNOLOGIC:
- HIV
- Chemotherapy-Current

PSYCHIATRIC:
- Depression
- ADD / ADHD
- Anxiety
- Other:

TOBACCO: Cigarettes, Cigars, Chewing?
Used For How Long? Amount?
Former User: YES NO Quit Date?

ALCOHOL - Beer, Wine, Liquor
Used For How Long? Amount?

ILLEGAL DRUGS Amount?
Used For How Long?

EXPOSURE/INFECTED:
Chlamydia, Gonorrhea, Hepatitis, HIV, Syphilis