eye-site

Patient History Questionnaire

****PLEASE PLAN TO ARRIVE 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT****

Patient Name: **Date of Birth:**

RECENT VISUAL SYMPTOMS

☐ Blur at Distance (driving)	☐ Itchy Eyes	☐ Eye Pain	☐ Floaters
☐ Blur at Near (reading)	☐ Red Eyes	☐ Burning Eyes	☐ Flashes
☐ Difficulty Seeing at Night	☐ Watery Eyes	☐ Headaches	☐ Color Vision
☐ Light Sensitivity	☐ Dry Eyes	☐ Double Vision	☐ Other_____
	☐ Tired Eyes	☐ Glare/Halos	

REVIEW OF SYSTEMS (Patient) – Do you have a history of any disease? Please circle or write in:

Yes	No	
☐	☐	**Eyes** -- Glaucoma / Cataract / Lazy Eye / Macular Degeneration / _____
☐	☐	**Constitutional** – Fever / Weight Loss / Weight Gain / _____
☐	☐	**Ears, Nose, Throat, Mouth** – Sinus Problems / Sore Throat / _____
☐	☐	**Cardiovascular** – High Blood Pressure / High Cholesterol / Heart disease /_____
☐	☐	**Respiratory** – Cough / Asthma / Emphysema / _____
☐	☐	**Gastrointestinal** – Diarrhea / Reflux / Pain / _____
☐	☐	**Genitourinary** – Kidney Problems / Prostate Problems / _____
☐	☐	**Musculoskeletal –** Arthritis / Joint Pain / Swollen Joints /_____
☐	☐	**Integumentary –** Skin Dryness / Rosacea /_____ _____
☐	☐	**Neurological** – Numbness / Headaches / Nausea / Multiple Sclerosis / _____
☐	☐	**Psychiatric** – Depression / Anxiety / _____
☐	☐	**Endocrine** – Thyroid Problems / Diabetes / _____hA1c:_____Blood Sugar:_____
☐	☐	**Hematological/lymphatic** – Blood Disorders / Leukemia / Anemia / _____
☐	☐	**Allergic/Immunologic** – Hay Fever / Seasonal Allergies / _____
☐	☐	**Others** – Cancer / Pregnant / _____

PAST HISTORY–please list all eye injuries or eye surgeries

_____

_____

****Email**:_____

MEDICATIONS - Please list any medications you take

_____

_____

_____

_____

_____

Family Physician Name:

Medication Allergies:

FAMILY HISTORY – Do your family members have any of the following? Please list relationship if known.

Yes	No		Yes	No		Yes	No	
☐	☐	Blindness_____	☐	☐	Glaucoma_____	☐	☐	Diabetes_____
☐	☐	Cataract_____	☐	☐	Macular Degeneration_____	☐	☐	High Blood Pressure_____
☐	☐	Diabetic Retinopathy_____	☐	☐	Retinal Detachment_____	☐	☐	Other _____

Yes	No	
☐	☐	Do you have prescription sunglasses?
☐	☐	Do you have more than 1 pair of current eyeglasses?
☐	☐	Do you currently wear contact lenses?
☐	☐	Are you interested in discussing/wearing contact lenses?
☐	☐	Do you use a computer?
☐	☐	Is there anything else you would like us to know about your eyes?

_____

SOCIAL HISTORY

Yes	No	
☐	☐	Do you use tobacco?
☐	☐	Have you ever used tobacco?
☐	☐	Do you drink alcohol?
☐	☐	Do you use drugs?

Occupation/School/:_____

Hobbies:_____

Race/Ethnicity: Native American/Caucasian/Asian/
African American/Hispanic/East Indian/Other_____

Height:_____ft._____in.
Weight:_____lbs.
Blood Pressure: ____/____

Patients Signature:_____ Date_____