Patient Health History Questionnaire

Patient's Name: ________________________________ **Date:** _________________

DOB: ___/___/_________ **SSN:** _____-_____-______ **DL#:** __________________

Address: ______________________________________ **Home:** (_____)______________________

______________________________________ **Cell:** (_____)______________________

Occupation: ___________________________________ **Email:** _____________________________

Medical Insurance:
____

Vision Insurance: □ VSP □ MES □ EyeMed □ Other: ___________________ □ Private Pay

Responsible party if different to patient: _____________________ **Relationship:** ________________

Ocular History

Do you wear glasses? □ No □ Yes **If yes, how old is your current pair of glasses?**_________________

Do you wear contact lenses? □ No □ Yes

If yes, what type? □ Rigid □ Soft □ Toric □ Multifocal □ Monovision

Do you wear them □ full time **or** □ part-time?

Replacement? _____________________ **Contact Lens Solution?** ____________________________

Are you experiencing any of the following problems with your eyes? Check if "Yes".

□ Blurry Vision	□ Itchy Eyes	□ Light Sensitivity	□ Styes/Chalazion
□ Double Vision	□ Tired Eyes	□ Flashes/Floaters in Vision	□ Halos/Glare
□ Distorted Vision	□ Dryness	□ Gritty/Sandy Feeling	□ Burning
□ Redness	□ Tearing/Watering	□ Eye Pain	□Mucous Discharge

□ Other: ____

Have you ever been diagnosed with any of the following?

□ Cataracts	□ Crossed Eyes	□ Macular Degeneration	□ Ocular Injury
□ Amblyopia/Lazy Eye	□ Retinal Detachment	□ Retinal Disease	□ Dry Eye

□ Ocular Surgery, type/date ______________________________________

Medical History

Family Doctor: ______________________________________ **Phone:** (_____)________________

______________________________________ **Last Medical Exam:**_____________

History of any surgeries or hospitalizations? ____

Allergies to medications? ____

Any other allergies or latex sensitivity?____

Current Prescription Medications:

-
-
-
-
-

Current Vitamins/Supplements/OTCs:

-
-
-
-
-

Review of Systems – Please check all that apply

Constitution
☐ Negative
☐ Cancer
☐ Fatigue

Ear/Nose/Throat
☐ Negative
☐ Sinusitis
☐ Dry mouth

Neurological
☐ Negative
☐ Multiple Sclerosis
☐ Epilepsy

Cardiovascular
☐ Negative
☐ Hypertension
☐ Stroke/CVA
☐ Heart Disease
☐ Congestive Heart Failure

Respiratory
☐ Negative
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Chronic obstruction

Gastrointestinal
☐ Negative
☐ Crohn's
☐ Ulcer
☐ Acid reflux
☐ Celiac's

Hematologic/Lymphatic
☐ Negative
☐ Anemia
☐ High Cholesterol
☐ Large volume blood loss

Musculoskeletal
☐ Negative
☐ Arthritis
☐ Fibromyalgia
☐ Muscular Dystrophy

Genitourinary
☐ Negative
☐ Kidney Disease
☐ Prostate disease/cancer
☐ STD – herpes, chlamydia etc

Integumentary
☐ Negative
☐ Eczema
☐ Rosacea
☐ Psoriasis
☐ Herpes simplex/cold sores
☐ Herpes zoster/shingles

Endocrine
☐ Negative
☐ Type II Diabetes Mellitus
Recent HA1C ________
☐ Type I Diabetes Mellitus
☐ Thyroid Dysfunction
☐ Hormonal Dysfunction

Allergy/Immunological
☐ Negative
☐ Drug allergies
☐ Environmental allergies
☐ Rheumatoid arthritis
☐ Sjorgren's syndrome
☐ Lupus

If you checked any of the above boxes or have any condition not listed, please explain:

____

Are you currently pregnant and / or nursing? ☐ **No** ☐ **Yes**

Family History (please note any parents, siblings, grandparents, children living or deceased)

Ocular	***Relationship to you***
☐ Cataracts	_____________
☐ Glaucoma	_____________
☐ Retinal Detachment	_____________
☐ Macular Degeneration	_____________
☐ Lazy eye/crossed eyes	_____________
☐ Other: _______________	_____________

Medical	***Relationship to you***
☐ High blood pressure	_____________
☐ Diabetes	_____________
☐ Heart Disease	_____________
☐ Cancer	_____________
☐ Lupus	_____________
☐ Disease	_____________
☐ Other: _______________	_____________