Patient History Questionnaire

Name of your **Medical** Doctor _____ Phone # of Medical Doctor _____
When was your last **health** exam? _____ When was your last **eye** exam? _____
What is the **main reason** for your visit today? _____

Major Illnesses or Injuries

Current Medications	For

Eye Drops

Surgeries	Date	Surgeon

****DRUG ALLERGIES****

Yes No Please list **below**

Current Eye Symptoms	Yes	No
Glaucoma		
Cataract		
Macular degeneration		
Retinal detachment		
Styes		
Blindness		
Lazy eye or eye turn		
Color blind		
Eye infection		
Itchy or red		
Floates/flashes or spots		
Glare/light sensitive		
Tired eyes		
Burning or dry		
Excess tearing		
Eye pain or soreness		
Sandy or gritty feeling		
Distorted/double vision		
loss of vision/side vision		
blurred vision-distance		
blurred vision-near		
Other		

Your Medical History	Yes	No
Allergies (seasonal)		
Ca - High Blood Pressure		
Ca - High Cholesterol		
Co - Weight Loss/Gain		
Cr - Headaches		
En - Diabetes		
En - Thyroid Problems		
Ga - Stomach Problems		
Ge - Kidney Stones		
He - Anemia/Blood Disorder		
Im - HIV, Herpes, Lyme		
In - Skin (Acne, Lupus)		
Mu - Arthritis, Osteoporosis		
Ne - MS, Seizures		
Ps - Anxiety, Depression		
Re - Asthma		
Cancer: type _____		
Are you pregnant/nursing?		

Family History Eye Diseases	Yes	No
Glaucoma		
Cataracts		
Macular degeneration		
Retinal detachment		
Blindness		
Lazy eye or eye turn		
Color Blind		
Systemic Disease	**Yes**	**No**
Arthritis		
Cancer		
Diabetes		
Heart disease		
High blood pressure		
Kidney disease		
Lupus		
Stroke		
Thyroid disease		
Thyroid		

Social History

Current Occupation	Do you use vitamins? Y or N
Computer use Y or N Hrs/day	Drink Alcohol? Y or N
Do you wear glasses? Y or N	Drinks/week
If yes: Full time Part time	Smoke? Y or N
Type of glasses owned:	Amount?
Do you wear contacts? Y or N	Hobbies/Interests :
If yes: what type?	Exercise? Y or N Times/Week

_____ _____

Signature of Patient **Date**