Today's Date _____

PATIENT HISTORY QUESTIONNAIRE

Last Name _____ First Name _____ Middle Initial _____

Address _____ Employer _____

_____ Occupation _____

Telephone (H) _____ (C) _____ (W) _____ Emergency Tel.# _____

Date of Birth _____ Patient's SSN _____ Member SSN for Insurance if different _____

Date of Last Exam _____ Email Address _____

MEDICAL INFORMATION ***I wish to have my eyes dilated today.*** ☐ **YES** ☐ **NO** ☐ RESCHEDULE

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

Current Medications (including oral contraceptives, aspirin, and over the counter medications): _____

_____

List all major injuries, surgeries, and/or hospitalizations: _____

_____

Are you pregnant and/or nursing? ☐ **YES** ☐ **NO**

Name of Medical Doctor: _____ Dr.'s Phone: _____ Date of Last Medical Exam: _____

PERSONAL & FAMILY MEDICAL HISTORY

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

	PERSONAL		**FAMILY**		
DISEASE/CONDITION	**NO**	**YES**	**NO**	**YES**	**RELATIONSHIP TO YOU**
Arthritis	☐	☐	☐	☐	_____
Blindness	☐	☐	☐	☐	_____
Cancer	☐	☐	☐	☐	_____
Cataract	☐	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	_____
Glaucoma	☐	☐	☐	☐	_____
Heart Disease	☐	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	☐	_____
Lupus	☐	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	☐	_____
Other _____	☐	☐	☐	☐	_____

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

PERSONAL EYE INFORMATION

Do you wear glasses? ☐ **NO** ☐ **YES** If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ **NO** ☐ **YES** If yes, how old is your present pair of lenses? _____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ **YES** ☐ **NO**

Are you renewing or obtaining a contact lens prescription? ☐ **YES** ☐ **NO** I do not intend to wear contacts or get any contact lens refills.

PLEASE NOTE: Contact Lens Services are not included in the annual exam fees. The contact lens exam is a separate exam to ensure proper fit of your contacts and evaluating your vision with the contacts. Additional time and material fees are required.

Do you use a computer? ☐ **NO** ☐ **YES** If yes, how many hours per day do you use the computer? _____

SOCIAL HISTORY *This information is strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ☐ **NO** ☐ **YES** If yes, do you have any difficulty when driving? ☐ **NO** ☐ **YES** If yes, please describe: _____

Do you use tobacco products? ☐ **NO** ☐ **YES** If yes, type/amount/how long: _____

Do you drink alcohol? ☐ **NO** ☐ **YES** If yes, type/amount/how long: _____

Do you use illegal drugs? ☐ **NO** ☐ **YES** If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

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REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	**NO**	**YES**	**?**
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐
ALLERGIC/IMMUNOLOGIC	☐	☐	☐

SYSTEM	**NO**	**YES**	**?**
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR/CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC/HEMATOLOIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

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

_____

_____

_____