PATIENT HISTORY QUESTIONNAIRE

Patient Name: ____ Date: __________________
Date of Birth: ________________ Age: _______Occupation: ______________________Marital Status: M W S D

1. What eye or general medical problem has brought you to the office today and how long has it existed? If job-related, include date of injury. ____
____

2. Please check any of the following you are experiencing:
   - ❑ Blurred/Distorted Vision
   - ❑ Loss of Side Vision
   - ❑ Double Vision
   - ❑ Floaters
   - ❑ Flashes of Light
   - ❑ Eye Injury
   - ❑ Eye Pain
   - ❑ Tearing
   - ❑ Itching
   - ❑ Crusting or Discharge
   - ❑ Redness of Eyes or Lids
   - ❑ Swelling of Eyelids
   - ❑ Growth on Eye or Lid
   - ❑ In- or Out-Turning of Eyes
   - ❑ Pupil Abnormality

3. Do you wear contact lenses? ☐ No ☐ Yes: ☐ Disposable ☐ Soft ☐ Rigid. Hours/day ______ Age, current pair? ________

4. Have you been treated for any eye disease?
   - ❑ Glaucoma
   - ❑ Retinal detachment
   - ❑ Cataract
   - ❑ RK/LASIK
   - ❑Wandering or "lazy" eye
   - ❑Other: ______________________

5. Have you ever been treated for any medical problems? (Please check all that apply.)
   - ❑ Heart disease
   - ❑ Hypertension
   - ❑ Vascular disease/Stroke
   - ❑ AIDS/Exposure to AIDS
   - ❑ Asthma
   - ❑ Emphysema
   - ❑ Tuberculosis
   - ❑ Cancer ______________
   - ❑ Liver disease/Hepatitis
   - ❑ Gastrointestinal disease
   - ❑ Kidney/Urinary disease
   - ❑ Other ____
   - ❑ Diabetes
   - ❑ Thyroid disorder
   - ❑ Neurologic disorder

6. Please list any laser, eye & general surgeries you have undergone: ______________________________
____

7. Please provide a list of your medications (prescription, nonprescription, herbals) dose, & how taken: ______________
____

8. Please list all drug/food/other allergies: ____

9. When was your last influenza/flu vaccination? ____

10. Review of Systems: Please check if you are experiencing any of the following:
   - ❑ Unexpected weight loss
   - ❑ Fatigue
   - ❑ Hearing loss
   - ❑ Sinus problems
   - ❑ Vertigo
   - ❑ Chest pain
   - ❑ Irregular heart beat
   - ❑ Shortness of breath
   - ❑ Wheezing
   - ❑ Coughing
   - ❑ Heartburn
   - ❑ Abdominal pain
   - ❑ Diarrhea
   - ❑ Vomiting
   - ❑ Pain on urination
   - ❑ Blood in urination
   - ❑ Skin rash/dryness
   - ❑ Muscle aches
   - ❑ Swollen or painful joints
   - ❑ Numbness or weakness
   - ❑ Paralysis
   - ❑ Headaches
   - ❑ Depression
   - ❑ Memory loss
   - ❑ Anxiety
   - ❑ ntolerance to heat or cold

11. Family History: Please check if any family history of eye or medical diseases:
   - Glaucoma
   - ❑ Macular degeneration
   - Crossed / lazy eye
   - ❑ Diabetes
   - ❑ Cancer
   - ❑ Other: _________________

<u>Please complete other side</u>

Please complete other side

12. Social History: Do you currently:

- ❑ Drink more than 1-2 alcoholic beverages daily
- ❑ Use tobacco? How Much?
- ❑ Use recreational drugs

- ❑ Do you feel unsafe in your home/relationship due to abuse?
- ❑ Have there been threats or direct abuse of you or your children?
- ❑ Are you currently or have you ever been treated for substance abuse or emotional problems?
- ❑ Are you currently having any thoughts of hurting yourself or taking your own life?
- ❑ In the last 12 months, was there a time when you needed to see a doctor, but could not because of funds?
- ❑ In the last 12 months, did you skip medications to save money?
- ❑ In the last 12 months, have you eaten less than you should because there wasn't enough money for food?
- ❑ Would you like to receive assistance with any of these needs? Yes No

	Patient/Responsible Party Signature :	**Date:**	**Physician Signature:**	**Date:**
1.	X______________________	__________	______________________	__________
2.	______________________	__________	______________________	__________
3.	______________________	__________	______________________	__________
4.	______________________	__________	______________________	__________