Patient History Questionnaire

Last Name____________________ First Name___________________ Date______________ DOB: _________

Email address:______________________________________ Phone number:__________________________

PERSONAL INFORMATION

1. What is the reason for your visit? __________________________

☐Routine eye exam ☐Decreased vision distance / near / both ☐Red Eye ☐Foreign object ☐Contact lens fit

2. When was your last eye exam? ____________________________

3. Have you had any eye injuries? ☐No ☐Yes

   a. Type of injury___________________________ When did it happen? _______________

4. Have you had any eye operations? ☐No ☐Yes

   Type of Operation______________________________ When was it done? ________________

5. Have eyeglasses ever been prescribed for you? ☐No ☐Yes

   Do you wear eye glasses now? ☐No ☐Full time ☐Part Time ☐Lost ☐Broken ☐Stolen

6. Have contact lenses ever been prescribed for you? ☐No ☐Yes

   Do you wear contact lenses now? ☐No ☐Full time ☐Part time

   Type and power of contact lenses___________________________

7. Please check any eye problems you have or previously had: If none check ☐ N/A

☐Crossed eyes ☐Cataracts ☐Skin ☐Endocrine (glands) ☐Floaters
☐Double Vision ☐Glaucoma ☐Seeing Flashes ☐Loss of Vision
☐Amblyopic (lazy eye) ☐Macular Degeneration ☐Retinal detachment ☐Other eye disease

PERSONAL HEALTH HISTORY

1. Do you have problems with any of the following? If none check ☐ N/A

☐Ears/nose/throat ☐Gastrointestinal ☐Skin ☐Endocrine
☐Cardiovascular ☐Genitourinary ☐Immune System ☐Blood/Lymph
☐Respiratory (breathing) ☐Musculoskeletal ☐Nervous System ☐Mental health

2. Have you been diagnosed with any of the following? If none check ☐ N/A

☐Diabetes ☐Hypertension ☐Thyroid ☐Rheumatoid arthritis ☐Stroke ☐Others

   When was it diagnosed? ____

   Is it controlled?____

3. Are you taking any medications? ☐No ☐Yes, Please list them: ______________________

____

4. Are you allergic to any medications? ☐No ☐Yes, Please list them: ___________________

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5. Have you had any operations? ☐No ☐Yes, What kind?___________________________

6. Do you use cigarettes/tobacco? ☐No ☐Yes, For how long? _______________________

7. Who is your Primary Care Physician?__________________________ Last visit?______________

FAMILY HISTORY

Please check if your Blood relatives have any of the following:

How are they related to you? Please SPECIFY: ____

☐Glaucoma: ☐Maternal ☐Paternal ☐Retinal disease: ☐Maternal ☐Paternal
☐Diabetes: ☐Maternal ☐Paternal ☐Age Related Macular degeneration: ☐Maternal ☐Paternal
☐Other: ☐Maternal ☐Paternal ☐Cataract: ☐Maternal ☐Paternal