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: _____

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. _____	_____	_____	_____