Patient History Questionnaire

Name_____ Date _____

Date of Birth_____

All Current Medications & Supplements: ☐ NONE ☐ SEE ATTACHED LIST

MEDICATION	DOSE	FREQUENCY

Eye Medications: ☐ NONE ☐ ARTIFICIAL TEARS

MEDICATION	FREQUENCY	WHICH EYE OR BOTH

Drug Allergies: ☐ NONE KNOWN_____

Past Surgeries: ☐ NONE

_____ DATE_____ _____ DATE _____
_____ DATE_____ _____ DATE _____
_____ DATE_____ _____ DATE _____

Eye History:

		YES	NO		YES	NO
Do You Have:	**Cataracts**	☐	☐	**Retina Problems**	☐	☐
	Glaucoma	☐	☐	**Laser Treatment**	☐	☐
	Eye Muscle problems	☐	☐	**Past Injury to either eye**	☐	☐
	Macular Degeneration	☐	☐	**Other**_____		

Do you wear contact lens? **YES** ☐ **NO** ☐
Do you want a contact lens prescription today? **YES** ☐ **NO** ☐

Social History: What is your occupation?_____ ☐ Student ☐ Retired ☐ Other_____

Family History: Does any close blood relative living or deceased have/had:

	YES	NO	RELATIONSHIP
Lazy Eye	☐	☐	_____
Glaucoma	☐	☐	_____

Do You Have A History Of:

	YES	NO	
Alcohol use	☐	☐	If yes, number of drinks you have daily____, weekly____
Non-prescription drug use	☐	☐	If yes, name of drug_____, amount_____
Do You Smoke?	☐	☐	If yes, how many years_____, # of packs per day_____
Have you ever smoked?	☐	☐	If yes, when did you quit_____
			How many years?_____, # of packs per day_____

(OVER)

Allergic / Immunologic	Yes	No	Explain if Yes
Seasonal allergies	☐	☐	________
Hayfever	☐	☐	________
Other Immune Problems	☐	☐	________
Other ________	☐	☐	________
Cardiovascular			
Congestive Heart Failure	☐	☐	________
Heart Attack	☐	☐	________
Irregular Heartbeat	☐	☐	________
Aneurysm	☐	☐	________
High Blood Pressure	☐	☐	________
High Cholesterol	☐	☐	________
Angina/Chest Pain	☐	☐	________
Swelling of feet/hands	☐	☐	________
Other ________	☐	☐	________
Constitutional			
Fever	☐	☐	________
Weight Loss	☐	☐	________
Other ________	☐	☐	________
Ear, Nose, Mouth, Throat			
Hearing Problems	☐	☐	________
Sinus Problems	☐	☐	________
Other ________	☐	☐	________
Integumentary			
Skin Disease	☐	☐	________
Other ________	☐	☐	________
Musculo - Skeletal			
Osteo Arthritis	☐	☐	________
Rheumatoid Arthritis	☐	☐	________
Other ________	☐	☐	________
Psychiatric			
Depression	☐	☐	________
Schizophrenia	☐	☐	________
Other ________	☐	☐	________
Cancer	☐	☐	________

Type________________________________

Endocrine	Yes	No	Explain if Yes
Diabetes	☐	☐	☐ Insulin ☐ Pills ☐ Diet
Thyroid Problems	☐	☐	________
Hormone Replacement	☐	☐	________
Other ________	☐	☐	________
Gastrointestinal			
Hepatitis	☐	☐	________
Ulcers	☐	☐	________
Hiatal Hernia / Reflux	☐	☐	________
Other ________	☐	☐	________
Genitourinary			
Kidney Disease	☐	☐	________
Men: Prostate Disease	☐	☐	________
Women: are you pregnant?	☐	☐	________
Post Menopause?	☐	☐	________
Other ________	☐	☐	________
Hematologic / Lymphatic			
Anemia	☐	☐	________
Bleeding disorder	☐	☐	________
Leukemia	☐	☐	________
Other ________	☐	☐	________
Neurological			
Multiple Sclerosis	☐	☐	________
Migraines	☐	☐	________
Convulsions, Seizures, Epilepsy	☐	☐	________
Stroke / Paralysis	☐	☐	________
Alzheimer's	☐	☐	________
Dementia	☐	☐	________
Other ________	☐	☐	________
Respiratory			
Asthma	☐	☐	________
Emphysema	☐	☐	________
Tuberculosis	☐	☐	________
Shortness of Breath	☐	☐	________
Other ________	☐	☐	________

Other past medical problems________________________________

Patient Signature ________________________________ **Date** ________________

For Office Use
Reviewed by

Tech_______	Physician_______	Date_______	Tech_______	Physician_______	Date_______	Tech_______	Physician_______	Date_______
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