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:

Do You Have:

	YES	NO		YES	NO
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____
Tech____	Physician____	Date____	Tech____	Physician____	Date____	Tech____	Physician____	Date____
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