Date:____/____/____

PATIENT HISTORY QUESTIONNAIRE

Last Name: ___________________________________ First Name: ________________________________ MI: _____ Date of Birth: ____/____/____

What is the main concern for today's visit? ____

Occupation: ____ Hobbies: ____

What kind of correction do you wear? None Glasses Hard Contacts Soft Contacts

Have you ever had an eye patched for any reason? Y / N If yes, why?: ____

Are you interested in Contact Lenses? Y / N If Yes, have you ever worn cl's? Y / N Date of last eye exam: _____/_____/_____ Were you dilated? Y / N

MEDICAL INFORMATION: Male [ ] Female [ ] - Are you post-menopausal? Y / N - Are you pregnant? Y / N

Name of primary care doctor: ____ Date of last visit: _____/_____/_____

Do you have problems with any of these systems? (Please circle yes or no for each system)

Gastrointestinal	Y / N	Nervous	Y / N	Eyes	Y / N	Allergic/ Immunologic	Y / N
Ears/Nose/Throat	Y / N	Genitourinary	Y / N	Mental	Y / N		
Cardiovascular	Y / N	Musculoskeletal	Y / N	Endocrine (glands)	Y / N		
Respiratory	Y / N	Integumentary-Skin	Y / N	Blood/lymph	Y / N		

Please explain:____

Allergies: ____ Allergies to Medications: ___________________________________

CURRENT MEDICATIONS: If none check here □

____

____

Alcohol: __________________________________ Tobacco: _____________________________ Drugs:___________________________________

Pharmacy Name: ____________________ Location: _____________________ Phone #: ________________________

EYE HEALTH HISTORY: Circle all that apply to you. If none of the below apply to you check here. □

Bloodshot Eyes	Discharge From Eyes	Eye Strain	Itching Eyes	Seeing Halos
Blurred Vision – Distance	Dizzy Spells	Fainting Spells, Blackouts	Lazy Eye	Seeing Flashes
Blurred Vision – Near	Double Vision	Floaters/Spots	Light Sensitive	Temporary Loss Of Vision
Burning Eyes	Dry Eyes	Glaucoma	Loss Of Vision	Twitching Eyelid
Cataracts	Eye Infection	Head Injury	Migraine Headaches	Watering Eyes
Color Vision Defect	Eye Injury	Head Surgery	Night Vision Poor	
Turned Eyes	Eye Operation	Headaches	Red Eyes	

GENERAL HEALTH & FAMILY HISTORY: Check all that apply to your family history. If none of the below apply to you check here. □

	Yourself	Family Member		Yourself	Family Member		Yourself	Family Member
Arthritis	[ ]	[ ]	Glaucoma	[ ]	[ ]	Migraine Headaches	[ ]	[ ]
Asthma	[ ]	[ ]	Hay Fever	[ ]	[ ]	Pacemaker	[ ]	[ ]
Blindness	[ ]	[ ]	Heart Condition	[ ]	[ ]	Poor Color Vision	[ ]	[ ]
Cancer	[ ]	[ ]	Hepatitis	[ ]	[ ]	Retinal Detachments	[ ]	[ ]
Cataracts	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Retinal Disease	[ ]	[ ]
Diabetes	[ ]	[ ]	High Cholesterol	[ ]	[ ]	Shingles	[ ]	[ ]
Please Circle Type: 1 or 2			HIV	[ ]	[ ]	Skin Conditions	[ ]	[ ]
Last Sugar______ Last A1C______			Kidney Disease	[ ]	[ ]	Stroke	[ ]	[ ]
Emphysema	[ ]	[ ]	Lazy Eye	[ ]	[ ]	Thyroid Disorder	[ ]	[ ]
Epilepsy	[ ]	[ ]	Lupus	[ ]	[ ]	Tuberculosis	[ ]	[ ]
Eye Surgery	[ ]	[ ]	Macular Degeneration	[ ]	[ ]	Turned Eye	[ ]	[ ]

Other health problems or surgeries: ____

DILATION OF PUPILS

We **may** need to dilate your pupils to examine the health of the inside of your eyes. This means you will be given drops that enlarge your pupils (the black circles inside your eyes). Dilation usually lasts 4 to 6 hours. You may experience some blurring, light sensitivity and difficulty reading during this time.

If over 18 y/o Patient's Signature:____

If under18 y/o Parent/Guardian Signature:____

Printed Name:____