APPT TIME:______________________

INSURANCE:____________________________________

PATIENT'S HEALTH QUESTIONNAIRE

LAST NAME:_______________________________ FIRST NAME:_______________________________ M_______
DATE OF BIRTH:_______________________________ TODAYS DATE:_________________________
SEX: MALE FEMALE PRIMARY CARE PHYSICIAN:__________________________________
Date of last eye exam:_________________________ Name of previous eye doctor:_________________________

Review of Eye Symptoms (CIRCLE ANY THAT APPLY)

□ **No Symptoms**

- -Blurred or Poor Vision -Red Eyes
- -Sensitivity to Light -Tearing
- -Double Vision -Dry Eyes
- -Eye Pain (Right/Left/Both) - Excessive Tearing
- -Episodic Loss of Vision -Poor Night Vision
- -Frequent/Forceful Blinking
- -Does your vision limit any activities of daily living (driving, reading, sports, work, etc?)
- -Floaters
- -Flashes of light

Family Eye History: Has any member of your Immediate family (blood relatives) have/had any of these diseases? If "yes," whom? □ **None**

- -Amblyopia
- -Strabismus (Eyes turning inward or outward)
- -Ptosis (Droopy Eyelids)
- -Macular Degeneration
- -Cataract
- -Glaucoma
- -Blindness
- -Corneal Disease
- -Retinal Detachment (RD)
- -Other eye diseases

Past Ocular/Medical HistoryAllergies:____

Past Eye History
Please circle any diseases that are or have been present? □ **None**

Amblyopia (Lazy Eye)
Strabismus (Eyes turning in/out)
Ptosis (Droopy Eyelids)
Cataract
Glaucoma
Diabetic Eye Disease
Macular Degeneration (ARMD)
Blindness
Corneal Disease
Retinal Detachment (RD)
Posterior Vitreous Detachment (PVD)
Eye Injury
Other eye disease ________________

Past Ocular Surgeries □ **None**

Laser Eye Surgery (LASIK)
Strabismus (Eye Muscle) Surgery
Cataract Surgery
Other Eye Surgery _____________

Current Eye Medications
□ **None**

Past Medical History: Circle any and all conditions that apply to you
□ **No Known Problems**

High Blood Pressure	Kidney Disease	Lupus
Heart Disease	Seizures	Anemia
Heart Attack	AIDS/HIV	Stroke
Congestive Heart Failure	Hepatitis	Dementia
High Cholesterol	Rheumatoid Arthritis	Diabetes
Asthma	Thyroid Disease	Blood Clots
COPD	Seasonal Allergies	
Cancer (type):__________	Others ______________________	

Past Surgeries □ **None**

Current Systemic Medications □ **None**

Aspirin
Blood Thinner

Family History □ **None**

□ Diabetes □ Stroke □ Blindness □ Macular Degeneration □ Arthritis □ Cancer □ TB □ Cataracts
□ Lazy Eye □ Glaucoma □ High Blood Pressure □ Heart Disease □ Kidney Disease □ Thyroid Disease
□ Other (explanation) ____________________________________

Social History

Are you (circle) Student Homemaker Employed

Are you (circle) Single Married Divorced Widowed

Smoking Status Smoker Non-smoker Former Smoker

Alcohol (circle) YES NO If yes, how much?__________________

Drugs YES NO Drugs used____

How much?____________________ How Long?_______________ When quit?__________

FEMALE PATIENTS: **PREGNANT** **YES** **NO**

BREAST FEEDING **YES** **NO**

Review of Systems

Eyes *
Previous Surgery □ YES □ NO
Contact Lenses □ YES □ NO
Pain □ YES □ NO
Double Vision □ YES □ NO
Glaucoma □ YES □ NO
Cataracts □ YES □ NO
Macular Degeneration □ YES □ NO
Dry Eyes □ YES □ NO
Flashes □ YES □ NO
Floaters □ YES □ NO

Respiratory *
Cough □ YES □ NO
Congestion □ YES □ NO
Wheezing □ YES □ NO
Asthma □ YES □ NO

Blood/Lymphnodes *
Easy Bruising □ YES □ NO
Gums Bleed Easily □ YES □ NO
Prolonged Bleeding □ YES □ NO
Heavy Aspirin Use □ YES □ NO

Gastrointestinal*
Heartburn □ YES □ NO
Nausea/Vomiting □ YES □ NO
Jaundice/Hepatitis □ YES □ NO

MusculoSkeletal *
Stiffness □ YES □ NO
Arthritis □ YES □ NO
Joint Pain/Swelling □ YES □ NO

Ear, Nose, and Throat *
Hard of Hearing □ YES □ NO
Ringing in Ears □ YES □ NO
Vertigo □ YES □ NO
Sinus Problem □ YES □ NO

Genito-Urinary *
Pain/Difficulty □ YES □ NO
Blood in Urine □ YES □ NO
History of Kidney Stones □ YES □ NO
History of STD's □ YES □ NO

Skin *
Rash/Sores □ YES □ NO
Lesions □ YES □ NO
Hives/Eczema □ YES □ NO

Cardiovascular *
Chest Pain □ YES □ NO
Dizziness □ YES □ NO
Fainting Spells □ YES □ NO
Shortness of Breath □ YES □ NO
Irregular Heart Beat □ YES □ NO
Difficulty Lying Flat □ YES □ NO

Psychiatric *
Anxiety/Depression □ YES □ NO
Mood Swings □ YES □ NO
Difficulty Sleeping □ YES □ NO

Neurological *
Seizures □ YES □ NO
Weakness/Paralysis □ YES □ NO
Numbness □ YES □ NO
Tremors □ YES □ NO
Headaches □ YES □ NO
Dizziness □ YES □ NO

Constitutional *
Fatigue/Weakness □ YES □ NO
Fever □ YES □ NO
Weight Gain/Loss □ YES □ NO

Endocrine *
Increased Thirst □ YES □ NO
Increased Hunger □ YES □ NO
Increased Urination □ YES □ NO
Increased Sweating □ YES □ NO
Fingernail Changes □ YES □ NO

Immunologic *
Hives □ YES □ NO
Itching □ YES □ NO
Runny Nose □ YES □ NO
Sinus Pressure □ YES □ NO

ADDITIONAL MEDICATIONS:

NAME	DOSAGE	FREQUENCY	REASON
1.____________	____________	____________	____________
2.____________	____________	____________	____________
3.____________	____________	____________	____________
4.____________	____________	____________	____________