PATIENT HISTORY QUESTIONNAIRE

Name _____ Date of Birth _____ Date _____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ Blurred Vision
- ☐ Burning
- ☐ Cataracts
- ☐ Cross Eyes
- ☐ Diabetes
- ☐ Double Vision
- ☐ Drooping Eyelid
- ☐ Dryness
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Eye Pain or Soreness
- ☐ Eye Surgery
- ☐ Foreign Body Sensation
- ☐ Floaters
- ☐ Glare/Light Sensitivity
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hypertension
- ☐ Lazy Eye
- ☐ Loss of Vision
- ☐ Loss of Side Vision
- ☐ Mucous Discharge
- ☐ Prominent Eye
- ☐ Redness
- ☐ Retinal Disease
- ☐ Seeing Flashes
- ☐ Seeing Halos
- ☐ Tired Eyes
- Other _____

Check (✓) if your blood relatives had any of the following		Relationship to you
	Blindness	
	Cataracts	
	Diabetes	
	Glaucoma	
	Other	

VISION CORRECTIONS

Do you wear eye glasses? ☐ Yes ☐ No

Please (circle)

Reading Distance Both

How old is your current prescription? _____

Do you wear contact lenses? Type _____

ALLERGIES you have to medications

Seasonal Allergies? Hay Fever?

MEDICATIONS List medications you are currently taking

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No

Number of packs per day _____

Do you drink? ☐ Yes ☐ No

Number of drinks per day _____

MAJOR ILLNESSES and INJURIES: Please list _____

SURGERIES: Please list _____

Have you or any member of your family experienced any problems with ANESTHESIA? ☐ Yes ☐ No

Please Complete Other Side

HEALTH HISTORY Check (✓) all that apply

Constitutional ☐ None
☐ Fever ☐ Weight Loss ☐ Malaise

Lung or Breathing ☐ None
☐ Chronic Bronchitis ☐ Asthma ☐ Emphysema ☐ COPD ☐ TB

Skin ☐ None
☐ Rashes ☐ Dermatologic Conditions

Heart or Circulation ☐ None
☐ Mitral Valve Prolapse ☐ Angina ☐ Irregular heart beat ☐ High Blood Pressure
☐ Pacemaker Date _____ ☐ Stroke Date _____

Digestive, Stomach or Liver problems? ☐ None (be specific) _____
_____

Urinary, Kidney or Bladder problems? ☐ None (be specific) _____
_____

Neurological ☐ None
☐ Migraine How often _____
☐ Frequent Headaches How often _____
☐ Seizures ☐ Convulsions ☐ Epilepsy

Diabetes ☐ Yes ☐ No
☐ Diet Control ☐ Oral Medication ☐ Insulin control/dosage: ____ ☐ Low Blood Sugar

Thyroid Condition ☐ Yes ☐ No

Cancer ☐ None Type _____
Chemotherapy? Explain: _____

Are you being treated for:
☐ Anxiety ☐ Depression ☐ Psychiatric Treatment
☐ Arthritis ☐ Rheumatoid Arthritis ☐ None of the above

Hematologic/Lymphatic problems? ☐ Yes ☐ No

High Cholesterol ☐ Yes ☐ No

PATIENT SIGNATURE: _____ DATE: _____

History reviewed: _____ No Changes _____ Additions as noted above

PHYSICIAN SIGNATURE: _____ DATE: _____