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.______________________	__________________	__________________	____________________