PATIENT HISTORY QUESTIONNAIRE

NAME:_____**DATE**_____

Last Eye Exam:_____/_____ **Last Eye Doctor:**_____
Month **Year**

Eye History: (Check all that apply)

___Headache	____Itching	____Loss of Side Vision
____Glare/Light Sensitivity	____Mucous Discharge	____Drooping Eyelid(s)
____Tired Eyes	____Blurred Distance Vision	____Redness
____Burning	___Blurred Near Vision	____Sandy/Gritty Feeling
____Lazy Eye	___Distorted Vision	____Crossed Eyes
____Dryness	___Double Vision	___Glaucoma
____Tearing/Watering	___ Floaters or Spots	____Cataracts
____Eye Pain/Soreness	___Fluctuating Vision	____Retinal Disease
____Foreign Body Sensation	___Eye Trauma	____Macular Degeneration
____Infection Eye/lid	___Eye Surgery	____ Other:_____

Current & Past Medical History: (Check all that apply)

____Fever	____Depression/Psychosis	____Thyroid Disease
____Weight Loss	____Kidney/Renal Problems	____Elevated Cholesterol
____Ear/Nose/Throat	____Arthritis/Joint/Bone Disease	____Allergies
____High Blood Pressure	____Acne/Skin problems	____HIV
___ Asthma/Bronchitis	____Stroke/Neurological Problems	____Disability
___ Ulcers/Gastritis	____ Diabetes	____Cancer

____Surgery in the past year:Specify_____
___ Other:_____

ALLERGIES To Drugs or Medications (List):_____
MEDICATION LIST:_____
_____
_____

Do you wear eyeglasses? ___ Y ___ N **Contacts**? ___ Y ___ N **Sunglasses**? ___Y___N

Glasses owned: ___Single Vision ___Bifocal ___Progressive ____Trifocal___Safety Glasses ___Sports Glasses

Do you experience discomfort from glare from either sunlight or headlights?___Y ___ N

Are you interested in contact lenses? ___Y ___ N **Refractive surgery?** ___Y ___N

Do you use a computer? __Y __ N **If so, how many hours per day?**_____**Distance from screen**_____

SOCIAL HISTORY: (Check all that apply):

____Alcohol Use ____Tobacco Use ____Drug Use

Do you engage in regular exercise? ____yes ____no

____Hobbies (List)_____ ____Sports (List)_____

FAMILY HISTORY: (Check all that apply):

____Lazy Eye	____Retinal Detachment	___ High Blood Pressure
____Blindness	____Crossed Eyes	____Kidney Disease
____Cataracts	____Arthritis	____Lupus
____Color Blindness	____Cancer	____Stroke
____Glaucoma	____Diabetes	___Thyroid
____Macular Degeneration	____Heart Disease	___ Other

PRIMARY CARE PHYSICIAN:
Name_____**Phone**_____
Address_____

PATIENT SIGNATURE:_____**DATE:**_____