Patient History Questionnaire

Name: _____ Birth Date: _____ Date:_____

Last eye exam: ____/____/_____ By: _____

Last medical exam: ____/____/_____ Primary Care Physician: _____

Do you wear contacts? ☐ YES ☐ NO Type: _____
Are you pregnant? ☐ YES ☐ NO Due Date: _____
Are you nursing? ☐ YES ☐ NO
Do you smoke? ☐ YES ☐ NO If yes, how much?_____
Do you drink alcohol? ☐ YES ☐ NO If yes, how much?_____

Medications: _____
_____
_____
_____
_____

Allergies to Medications: _____

Eye Surgeries or injuries: _____

Circle any that apply		***Explain***
Eyes Glaucoma, cataracts, macular degeneration, eye injury, retinal disease, cross or drifting eye, lazy eye, dry eyes, double vision, pain, blurred vision	☐ YES ☐ NO	
Constitutional Fever, weight loss, other	☐ YES ☐ NO	
Cardiovascular Heart problems, hypertension, irregular heart beat	☐ YES ☐ NO	
Ears, Nose, Mouth, Throat Hearing loss, sinus problems, sore throat	☐ YES ☐ NO	
Respiratory Asthma, shortness of breath, wheezing, coughing	☐ YES ☐ NO	
Gastrointestinal Heartburn, abdominal pain, diarrhea, vomiting, ulcer	☐ YES ☐ NO	
Genitourinary Kidney failure, ovarian cancer, prostate cancer	☐ YES ☐ NO	
Musculoskeletal Muscle aches, joint pain, swollen ankles	☐ YES ☐ NO	
Integumentary (Skin) Skin rashes, excessive dryness	☐ YES ☐ NO	
Neurological Numbness, weakness, headaches, paralysis, stroke	☐ YES ☐ NO	
Psychiatric Depression, anxiety	☐ YES ☐ NO	
Endocrine Thyroid problems, diabetes	☐ YES ☐ NO	
Hematologic/Lymphatic Blood disorders, leukemia	☐ YES ☐ NO	
Allergic/Immunologic HIV, Lupus, seasonal allergies	☐ YES ☐ NO	
Other	☐ YES ☐ NO	

Family History: Do any medical or eye disease run in your family. If yes, please note relationship to patient.

☐ Glaucoma _____ ☐ High blood pressure _____
☐ Diabetes _____ ☐ Macular degeneration _____