PATIENT HISTORY QUESTIONNAIRE

COMPREHENSIVE
EYE CARE
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Name____Date of Birth________________Today's Date__________________

*Please fill out the following form. If you need additional room for more detailed answers please use the area provided on that back of this form entitled "**ADDITONAL NOTES**." Thank you.*

PERSONAL EYE HISTORY:

Date of Last Eye Exam ____________________

Cataract No ☐ Yes ☐
Glaucoma No ☐ Yes ☐
Macular Degeneration No ☐ Yes ☐
Blindness No ☐ Yes ☐
Retinal Detachment No ☐ Yes ☐

Injury to Eye or Head No ☐ Yes ☐
Foreign Body Removed No ☐ Yes ☐
Explain ________________________
Amblyopia (Lazy Eye) No ☐ Yes ☐
Strabismus (Eye Turn) No ☐ Yes ☐

Contact Lens Wearer No ☐ Yes ☐
CL Type ____________ Daily ☐ Extended ☐
Eye Infections No ☐ Yes ☐
Eye Surgery No ☐ Yes ☐
Explain__________________________
Other ___________________________

SELF - HEALTH HISTORY:

Primary Care Physician ____________________ Other Physicians____

Constitutional Symptoms

Developmental Disability No ☐ Yes ☐
Recent Weight Change No ☐ Yes ☐
Fever No ☐ Yes ☐
Fatigue No ☐ Yes ☐
Shortness of Breath No ☐ Yes ☐
Other:______________________________
Onset Date:__________________________

Ears/ Nose/ Mouth/Throat

Chronic Sinus Problems No ☐ Yes ☐
Allergies/ Hay Fever No ☐ Yes ☐
Other:______________________________
Onset Date:__________________________

Respiratory

Asthma/ Bronchitis No ☐ Yes ☐
Emphysema No ☐ Yes ☐
Other:______________________________
Onset Date:__________________________

Hematologic/Lymphatic

Anemia No ☐ Yes ☐
Leukemia No ☐ Yes ☐
Bleeding Problems No ☐ Yes ☐
Other:_____________________________
Onset Date:_________________________

Cardiovascular

Heart Problems No ☐ Yes ☐
High Blood Pressure No ☐ Yes ☐
Stroke/ Vascular Disease No ☐ Yes ☐
Other:______________________________
Onset Date:__________________________

Gastrointestinal

Crohn's Disease No ☐ Yes ☐
Ulcer No ☐ Yes ☐
Other:______________________________
Onset Date:__________________________

Genitourinary

Urinary Tract Infections No ☐ Yes ☐
Kidney Problems No ☐ Yes ☐
STD's (HIV, Herpes, Chlamydia) No ☐ Yes ☐
Other:____________________________
Onset Date:________________________

Endocrine

Non-insulin Dependent Diabetes No ☐ Yes ☐
Insulin Dependent Diabetes No ☐ Yes ☐
Thyroid Problems No ☐ Yes ☐
Other:____________________________
Onset Date:________________________

Muskuloskeletal

Arthritis No ☐ Yes ☐
Fibromyalgia No ☐ Yes ☐
Muscular Dystrophy No ☐ Yes ☐
Other:____________________________
Onset Date:________________________

Neurological

Multiple Sclerosis No ☐ Yes ☐
Epilepsy No ☐ Yes ☐

Psychiatric

Depression No ☐ Yes ☐
Nervousness/ Panic Disorder No ☐ Yes ☐
Schizophrenia No ☐ Yes ☐
Other:____________________________
Onset Date:________________________

Allergic/Immunologic

HIV/ AIDS No ☐ Yes ☐
Lupus No ☐ Yes ☐
Cancer No ☐ Yes ☐
Environmental/Food Allergy No ☐ Yes ☐
Other:____________________________
Onset Date:________________________

Please list all major injuries, surgeries, and /or hospitalizations you have had:

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SOCIAL HISTORY

Do you use cigarettes/ tobacco No ☐ Yes ☐ Amount/ How Long ____________________
Do you drink alcohol No ☐ Yes ☐ Amount/ How Long ____________________
Do you use illegal substances No ☐ Yes ☐ Amount/ How Long ____________________

PATIENT DRUG ALLERGIES OR SENSITIVITIES ____

____

MEDICATIONS

Please complete this table or submit a list to be attached.

Medication	For Condition	Dosage	Date Begun

Health History & Medications Reviewed by:

Drs. Initials _____ Pts. Initials _______ Date _______
Drs. Initials _____ Pts. Initials _______ Date _______
Drs. Initials _____ Pts. Initials _______ Date _______
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FAMILY (BLOOD RELATIVES) HEALTH HISTORY

Cataract No ☐ Yes ☐
Glaucoma No ☐ Yes ☐
Macular Degeneration No ☐ Yes ☐
Blindness No ☐ Yes ☐
Retinal Detachment No ☐ Yes ☐
Other __________________________

Diabetes No ☐ Yes ☐
High Blood Pressure No ☐ Yes ☐
Heart Problems/Stroke No ☐ Yes ☐
Thyroid Problems No ☐ Yes ☐
Cancer No ☐ Yes ☐
Arthritis No ☐ Yes ☐

List any other pertinent health problems that run in your family:

____
____
____
____

ADDITIONAL NOTES: ________________________________

____
____
____
____

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