



***Patient History Questionnaire***

Name: \_\_\_\_\_ Birth Date : \_\_\_/\_\_\_/\_\_\_ Sex: M F  
Street Address: \_\_\_\_\_ City/State/Zip : \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ Work phone : ( ) \_\_\_\_\_  
SS# \_\_\_/\_\_\_/\_\_\_ Email : \_\_\_\_\_

Do you have eye insurance? Yes No Name of insurance company: \_\_\_\_\_

Do you have medical insurance? Yes No Name of insurance company: \_\_\_\_\_

How did you learn of our office?  Relative  Friend  Insurance  Yellow Pages  Yellow Book  Website

Do you wear glasses? Yes No Contact Lenses? Yes No

Have you had eye surgery? Yes No What kind \_\_\_\_\_ Date \_\_\_\_\_

Have you had an eye injury? Yes No What kind \_\_\_\_\_ Date \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Last visit with your PCP: \_\_\_\_\_

**YOUR MEDICAL HISTORY** Do you have or have you had in the past any of the following conditions:  
High Blood Pressure No Yes Diabetes No Yes  
Cancer No Yes Heart Disease No Yes  
Thyroid Disease No Yes Arthritis No Yes

List all medications that you currently take. (Include oral contraceptives, aspirin, over the counter medications and home remedies):  
\_\_\_\_\_

Are you pregnant, nursing and/or do you think you maybe pregnant? NO YES

List all major surgeries and/or hospitalizations you have had: \_\_\_\_\_

Are you allergic to any medications? No Yes If yes please list: \_\_\_\_\_

**YOUR FAMILY HISTORY** Do any of your blood relatives have the following conditions:  
Crossed eyes No Yes Diabetes No Yes  
Lazy eye No Yes Heart Disease No Yes  
Macular degeneration No Yes High Blood Pressure No Yes  
Glaucoma No Yes Cancer No Yes  
Retinal detachment No Yes Thyroid Disease No Yes

**YOUR EYE HISTORY** Do you have or have you had in the past any of the following conditions:  
Crossed eyes No Yes Glaucoma No Yes  
Lazy eye No Yes Retinal detachment No Yes  
Macular degeneration No Yes Cataract No Yes

**YOUR SOCIAL HISTORY**  
Do you use tobacco products? No Yes If yes, how many packs/cigars per day:  
Do you drink alcohol? No Yes If yes, how many drinks per day:

***Patient History Questionnaire Cont.***

REVIEW OF SYSTEMS Do you currently have any of the problems listed below?

**Eyes:**

Loss of side vision	No	Yes
Blind spot in vision	No	Yes
Distorted vision/halos	No	Yes
Mucous discharge	No	Yes
Burning eyes	No	Yes
Dry eyes	No	Yes
Red eyes	No	Yes
Watering eyes	No	Yes
Itching	No	Yes
Light sensitivity	No	Yes
Flashes	No	Yes
Floaters	No	Yes
Double Vision	No	Yes

**Constitutional**

Recent fevers	No	Yes
Weight gain/loss	No	Yes

**Neurological**

Headaches	No	Yes
Numbness	No	Yes

**Ears/Nose/Throat**

Hearing loss	No	Yes
Sinus infection	No	Yes
Sore throat	No	Yes

**Endocrine**

Frequent urination	No	Yes
Frequent thirst	No	Yes

**Respiratory**

Sleep Apnea	No	Yes
Breathing difficulty	No	Yes
Chronic cough	No	Yes

**Vascular/Cardiovascular**

Chest pain	No	Yes
Irregular heart beat	No	Yes
Swelling of legs	No	Yes

**Gastrointestinal**

Gastric Reflex/Heartburn	No	Yes
Abdominal pain	No	Yes

**Genitourinary**

Crohn's Disease	No	Yes
Painful urination	No	Yes
Blood in urine	No	Yes

**Bones/Joints/Muscles**

Swollen joints	No	Yes
Joint pain	No	Yes
Muscle aches	No	Yes

**Lymphatic/Hematologic**

Anemia	No	Yes
Bleeding problems	No	Yes
Swollen glands	No	Yes

**Psychiatric**

Depression	No	Yes
Anxiety	No	Yes

**Allergic/Immunologic**

Autoimmune Disorders	No	Yes
Airborne allergies	No	Yes
Frequent infections	No	Yes

If you answered yes to any of the questions, please explain below: \_\_\_\_\_

Patient or Parental Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_