Patient History Questionnaire

Name_____

Occupation_____**Hobbies**_____

Current Ocular Concerns (check if applies to you)

WITH Glasses ☐ Difficulty reading small print ☐ Difficulty reading at the computer ☐Difficulty with distance vision
WITHOUT Glasses ☐ Difficulty reading small print ☐ Difficulty reading at the computer ☐Difficulty with distance vision

Burning	☐	☐	Fluctuating vision _____
Chronic infection of eyes or lids	☐	☐	Foreign body sensation _____
Distorted vision	☐	☐	Bothered by glare or reflections _____
Double vision	☐	☐	Pain or soreness _____
Dryness	☐	☐	Redness _____
Excess tearing/watering	☐	☐	Itching _____
Loss of vision	☐	☐	Other _____

Past Ocular Problems

Eye Injury, Surgery or Trauma	☐	Explain _____
Head Trauma	☐	Explain _____
Eye Infection	☐	Explain _____
Macular or Retinal Problems	☐	Explain _____
Glaucoma	☐	Explain _____
Lazy or Turned Eye	☐	Explain _____

Current Medications and Reason Prescribed:

1._____For_____ 2._____ ___For_____
3._____For_____ 4. _____For_____
5._____For_____ 6. _____For_____
7._____For_____ 8. _____For_____

List all allergies to medications _____
List all environmental allergies _____

Past or current medical conditions

Please check **YES** or **NO**, in boxes, **IF YES, PLEASE EXPLAIN**

General Symptoms ..... Yes☐ NO☐ (If no, proceed to next topic)

Currently Pregnant	☐	☐	_____
Headache	☐	☐	_____
Seasonal Allergy	☐	☐	_____
Blackouts	☐	☐	_____
Other	☐	☐	_____

Cardiovascular ..... Yes ☐ NO☐ (If no, proceed to next topic)

Heart Attack	☐	☐	_____
Arteriosclerosis	☐	☐	_____
High Cholesterol	☐	☐	_____
High Blood Pressure	☐	☐	_____
Other	☐	☐	_____

Endocrine ..... Yes ☐ NO☐ (If no, proceed to next topic)

Diabetes	☐	☐	Type_____Start of Treatment _____
Thyroid problems	☐	☐	Hypo_____Hyper _____
Pituitary Disorder	☐	☐	_____
Other	☐	☐	_____

Gastrointestinal (Stomach/Intestines) ..... Yes ☐ NO☐ (If no, proceed to next topic)

Diagnosis	☐	☐	_____

Genitourinary ..... Yes ☐ NO☐ (If no, proceed to next topic)

Frequent Urinating	☐	☐	_____
Other	☐	☐	_____

Hematological/Lymphatic ..... Yes ☐ NO ☐ (If no, proceed to next topic)

Hodgkin's Disease	☐	☐	_____
Anemia	☐	☐	_____
Swollen Lymph Nodes	☐	☐	_____
Other	☐	☐	_____

Immunologic ..... Yes ☐ NO ☐ (If no, proceed to next topic)

AIDS	☐	☐	_____
Lupus	☐	☐	_____
Herpes Simplex or Zoster	☐	☐	_____
Sjogren's Syndrome	☐	☐	_____
Other	☐	☐	_____

Integumentary ..... Yes ☐ NO ☐ (If no, proceed to next topic)

Mole changes around eyes	☐	☐	_____
Rash/ Itch around eyes	☐	☐	_____
Skin Cancer	☐	☐	_____
Other	☐	☐	_____

Musculo-Skeletal ..... Yes ☐ NO ☐ (If no, proceed to next topic)

Arthritis	☐	☐	_____
Back Pain	☐	☐	_____
Muscle Pain/ Weakness	☐	☐	_____
Other	☐	☐	_____

Neurological ..... Yes ☐ NO ☐ (If no, proceed to next topic)

Dizzy	☐	☐	_____
Seizures	☐	☐	_____
Multiple Sclerosis	☐	☐	_____
Other	☐	☐	_____

Psychiatric ..... Yes ☐ NO ☐ (If no, proceed to next topic)

Diagnosis	☐	☐	_____

Respiratory (Lungs/Breathing) ..... Yes ☐ NO ☐ (If no, proceed to next topic) _____

COPD	☐	☐	_____
Asthma	☐	☐	_____
Other	☐	☐	_____

Past Surgical History (All):

_____

_____

Describe any other problems, illnesses, surgeries or medicines that were not described in the above questions.

_____

_____

Family/Social History:

Yes	No		Yes	No	
☐	☐	High Blood Pressure- Relation:_____	☐	☐	Glaucoma- Relation:_____
☐	☐	Diabetes – Relation:_____	☐	☐	Cataracts- Relation:_____
☐	☐	Cancer- type:_____Relation:_____	☐	☐	Blindness- Cause_____Relation:_____
☐	☐	Other, Please explain_____	☐	☐	Retinal detachment- Relation:_____

Other_____

Past, Family, Social History

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Social History

Do you use cigarettes/tobacco? _____ Alcohol? _____ Drugs? _____

Patient Signature_____ Date_____ Reviewed_____/_____/_____

Dr. Reviewed_____/_____/_____/_____