PATIENT HISTORY QUESTIONNAIRE

Today's Date:_____

1. PERSONAL INFORMATION

Last Name:_____ First Name:_____ MI:_____

Title: Mrs. _____ Ms. _____ Miss _____ Mr. _____ Dr. _____ Other: _____

Street Address:_____

City:_____ State:_____ Zip_____

Home Phone #:_____ Work Phone #_____ Ext.:_____

Cell Phone # _____ Email: _____

Date of Birth:_____ Social Security No._____

Occupation:_____ Employer:_____

Interests/Hobbies:_____

Whom may we thank for referring you?_____

[Doctor – Another Patient –Internet, etc.]

2. EYE HEALTH HISTORY:

Date of last eye exam?_____ Name of Doctor:_____

Have you had any eye operations? Y/N Type:_____ Date:_____

Have you had an eye injury? Y/N Kind:_____ Date:_____

Do you wear glasses? Y/N If yes, circle all that apply: all the time – occasionally – reading – driving -- TV

Describe any problems you have with your glasses:_____

_____

Do you wear contacts? Y/N Type:_____ Hours/Day_____

Describe any problems you have with your contacts:_____

_____

Please indicate whether you have had any of the following:

Blurred Vision-Distance	Y/N	Bloodshot Eyes	Y/N	Temporary Loss of Vision	Y/N
Blurred Vision- Near	Y/N	Floaters or Spots	Y/N	Seeing Halos	Y/N
Eye Strain	Y/N	Seeing Flashes	Y/N	Twitching Eyelid	Y/N
Headaches	Y/N	Double Vision	Y/N	Eye infection	Y/N
Dry Eyes	Y/N	Light Sensitivity	Y/N	Crossed Eyes	Y/N
Watering Eyes	Y/N	Night Vision, Poor	Y/N	Cataracts	Y/N
Burning Eyes	Y/N	Dizzy Spells	Y/N	Glaucoma	Y/N
Itching Eyes	Y/N	Discharge from Eyes	Y/N	Color Vision, Poor	Y/N

Please note, based on the scale below, if you are suffering from any of the following signs or symptoms:

1 = never / 2 = seldom / 3 = occasionally / 4 = often / 5 = always

Physical Signs: Do you. . .		**Primary Symptoms:** Do you. . .		**Secondary Symptoms:** Do you. . .	
get headaches after close work with reading, computer, etc.?		have trouble copying words from one source to another?		have a short attention span?	
hold books extremely close?		avoid reading?		have frustration and anxiety associated with near tasks?	
cover one eye by leaning on a hand?		lose place when reading?		have inconsistent or poor sports performance?	
fall asleep when reading?		skip or reread words and lines?		estimate distances incorrectly?	
feel that words run together and/or double when reading?		have poor organization on paper-letter and word spacing, margins, columns?		tend toward clumsiness?	
see blurred across the room after		have difficulty remembering what			

reading, writing or computer work?		you have read?			

3. MEDICAL INFORMATION:

When was your last general health exam?_____ Name of family doctor?_____

List any medications you are currently taking:_____

_____

List any eye drops you are currently using:_____

Do you have any allergies to medication? _____

Do you have other allergies?_____

Do you use cigarettes/tobacco? Y/N Alcohol? Y/N Other Substances?_____

Please indicate if you or a blood relative has had any of the following problems:

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	Y/N	Y/N	Heart Condition	Y/N	Y/N
Arthritis	Y/N	Y/N	Hepatitis (Type ___)	Y/N	Y/N
Artificial Valve	Y/N	Y/N	High Blood Pressure	Y/N	Y/N
Artificial Joint	Y/N	Y/N	High Cholesterol	Y/N	Y/N
Asthma	Y/N	Y/N	Hypoglycemia	Y/N	Y/N
Bleeding	Y/N	Y/N	Kidney Disease	Y/N	Y/N
Blindness	Y/N	Y/N	Lazy Eye	Y/N	Y/N
Cancer	Y/N	Y/N	Migraine Headaches	Y/N	Y/N
Cataracts	Y/N	Y/N	Pacemaker	Y/N	Y/N
Chemical Dependency	Y/N	Y/N	Poor Color Vision	Y/N	Y/N
Diabetes	Y/N	Y/N	Retinal Disease	Y/N	Y/N
Drug Sensitivity	Y/N	Y/N	Rheumatic Disease	Y/N	Y/N
Emphysema	Y/N	Y/N	Shingles	Y/N	Y/N
Epilepsy	Y/N	Y/N	Skin Conditions	Y/N	Y/N
Eye Surgery	Y/N	Y/N	Stroke	Y/N	Y/N
Glaucoma	Y/N	Y/N	Thyroid Conditions	Y/N	Y/N
Hay Fever	Y/N	Y/N	Tuberculosis	Y/N	Y/N
			Turned Eye	Y/N	Y/N

4. SUPPLEMENTAL INFORMATION:

Please use the space below to provide us with any additional information about yourself which would further assist us during the evaluation.

_____

_____

_____

_____

_____