Patient Questionnaire

Dear Patient,

All major health insurers and Medicare now **require** us to obtain in-depth patient medical history information. We apologize for the time required to fill out this form and thank you for your cooperation. All responses are kept confidential.

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

Last Name: _____

First Name: _____MI_____

Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _(_____)_____-_____

Home Phone: _(_____)_____-_____

Work Phone: _(_____)_____-_____

Please circle your preferred contact number.

May we contact you via email? **Y N**

Email:_____

Today's Date: _____/_____/_____

Birthdate: _____/_____/_____

Gender: **M F** Marital Status: _____

SS# ***(required for insurance)*** _____-____-_____

Driver's License #: _____

Occupation: _____

Employer / School:

_____

Who can we thank for referring you to us?

_____

Ocular HISTORY

Reason for Visit _____

Please check the boxes corresponding to the symptoms you currently have.

- ☐ Pain
- ☐ Double vision
- ☐ Loss of vision
- ☐ Headaches
- ☐ Flashes of light
- ☐ Floaters
- ☐ Foreign body sensation
- ☐ Dryness, sandiness, grittiness
- ☐ Itching
- ☐ Tearing, burning
- ☐ Redness
- ☐ Haloes, glare

Please check the boxes corresponding to any conditions or surgical procedures you have had.

- ☐ Macular degeneration
- ☐ Eye injections
- ☐ Glaucoma
- ☐ Glaucoma surgery or laser
- ☐ Retinal detachment
- ☐ Retinal surgery
- ☐ Retinopathy
- ☐ Foreign body removal
- ☐ Infection
- ☐ Cataract
- ☐ Cataract surgery
- ☐ LASIK / PRK
- ☐ Strabismus or eye turn
- ☐ Vision therapy
- ☐ Strabismus surgery
- ☐ Eye trauma

Please list any current **eye** medications you are using:

_____

Last eye exam: _____ Doctor:_____

Glasses: Y N	**Contacts**: Y N	Type: soft / gas permeable /	Wear: _____hrs/day
How old?	Brand:	monovision / toric / multifocal	Frequency: _____days/wk
Used for: Far Near Both	Disposal:	Cleaner:	Comfortable: _____hrs/day

Social History

Tobacco use? Y N	Type:	Frequency:	How long?	
Alcohol consumption? Y N	Type:	Frequency:		
Illegal drug use? Y N	Type:	Frequency:		
Sexually transmitted disease? Y N	Type:	Treatment:		
Race:	Ethnicity:	Preferred language:		
Do you drive? Y N	Computer use:_____hrs/day	Cell phone/tablet use: ___hrs/day		

Medical History

Pregnant or Nursing? Y N

General	Y	N	Genital, Kidney, Bladder	Y	N	Neurologic, Psychiatric	Y	N
Fever, fatigue			Prostate: hypertrophy, cancer			ADD, ADHD		
Weight loss/gain			Kidney disease			Anxiety		
Ear, Nose, Throat	Y	N	Muscles, Bones, Joints	Y	N	Depression		
Cough, dry mouth			Arthritis			Dementia, Alzheimer's		
Runny nose, congestion			Joint, muscle pain			Parkinson's		
Hearing loss			Gastrointestinal	Y	N	Endocrine	Y	N
Cardiovascular	Y	N	Crohn's Disease			Diabetes		
Heart disease, vascular disease			IBS			Thyroid: hyper, hypo, Grave's		
High cholesterol			Diarrhea			Blood/Lymphatic	Y	N
Hypertension			Constipation			Anemia		
Respiratory	Y	N	Skin	Y	N	Bleeding disorder		
Asthma, COPD			Eczema			Sickle cell		
bronchitis			Rosacea			Allergic, Immunologic	Y	N
emphysema						Seasonal		

Other conditions not specified above:_____

Please list the medications (prescription ***and*** non-prescription) you are currently taking or provide a list to our staff:

Medication	Dose	Medication	Dose

Please list any allergies (including environmental and medication) you have:

_____

Family Hx

Condition	Y	N	Family member(s)	
Glaucoma				
Early onset cataracts				Age diagnosed?
Macular Degeneration				Wet or dry?
Retinal Detachment				
Retinal Disease				Type of disease?
Eye Surgery				Type of surgery?
Strabismus or Amblyopia				History or vision therapy? Patching?
Other:				
Diabetes				
Hypertension				
High Cholesterol				
Heart Disease				
Thyroid Disease				
Cancer				Type of cancer?
Other:				