

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: _____	Today's Date: ____/____/____	
Last Name: _____	Birthdate: ____/____/____	
First Name: _____ MI _____	Gender: M F Marital Status: _____	
Nickname: _____	SS# (required for insurance) ____-____-____	
Address: _____	Driver's License #: _____	
City: _____ State: ____ Zip: _____	Occupation: _____	
Cell Phone: _(____)____-____	<i>Please circle your preferred contact number.</i>	Employer / School: _____
Home Phone: _(____)____-____		Who can we thank for referring you to us? _____
Work Phone: _(____)____-____		
May we contact you via email? Y N		
Email: _____		

Ocular HISTORY

Reason for Visit _____

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

<input type="checkbox"/> Pain	<input type="checkbox"/> Flashes of light	<input type="checkbox"/> Itching
<input type="checkbox"/> Double vision	<input type="checkbox"/> Floaters	<input type="checkbox"/> Tearing, burning
<input type="checkbox"/> Loss of vision	<input type="checkbox"/> Foreign body sensation	<input type="checkbox"/> Redness
<input type="checkbox"/> Headaches	<input type="checkbox"/> Dryness, sandiness, grittiness	<input type="checkbox"/> Haloes, glare

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

<input type="checkbox"/> Macular degeneration	<input type="checkbox"/> Retinal detachment	<input type="checkbox"/> Infection	<input type="checkbox"/> Strabismus or eye turn
<input type="checkbox"/> Eye injections	<input type="checkbox"/> Retinal surgery	<input type="checkbox"/> Cataract	<input type="checkbox"/> Vision therapy
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Retinopathy	<input type="checkbox"/> Cataract surgery	<input type="checkbox"/> Strabismus surgery
<input type="checkbox"/> Glaucoma surgery or laser	<input type="checkbox"/> Foreign body removal	<input type="checkbox"/> LASIK / PRK	<input type="checkbox"/> Eye trauma

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

Last eye exam: _____ Doctor: _____

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