VISION HEALTH
Trust the Health of Your Eyes to Us

Patient History Questionnaire

Full name: _____ Birth Date: _____/_____/_____
Address: _____ Social Security #:_____
_____
Email Address: _____ Home Phone: _____
Occupation: _____ Cell Phone: _____
Employer: _____ Work Phone: _____
Medical Doctor: _____ Driver's License: _____
Medical Insurance: _____ Last Medical Exam:____/_____/_____
Previous Eye Doctor: _____ Last Eye Exam:_____/_____/_____
Vision Insurance: ____VSP ____MES ____EyeMed ____Other:_____
Responsible Party, if different:_____ **Relationship to Patient:** _____
Phone:_____ **Billing Address, if different:** _____
Whom may we thank for referring you to our office: _____

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

Ocular History

Do you wear glasses? ☐No ☐Yes If yes, how old?_____ lens type?_____

Do you wear contact lenses? ☐No ☐Yes If yes, what type? ☐RGP ☐Soft ☐Toric ☐Multifocal

☐Monovision Do you wear them: ☐Full time ☐Part time

How frequently do you replace them? _____

Have you had refractive surgery?_____ If yes, date_____ Type_____

What other services would you like to be evaluated for? ☐ Refractive surgery ☐Contact Lenses ☐ Sunglasses

☐Computer Glasses ☐ Reading Glasses ☐ Driving Glasses

Are you having any visual difficulties?____ If yes, please explain _____

Are you currently experiencing any of the following problems with your eyes? **Check the box if "Yes."**

☐Blurred / Poor Vision
☐Loss of Vision
☐Blindness / Blackouts
☐Loss of Side Vision
☐Distorted Vision
☐Double Vision
☐Flashes / Floaters
☐Tired Eyes
☐Halos / Glare / Light sensitivity
☐Dryness
☐Sandy or Gritty Feeling
☐Burning
☐Redness
☐Itching
☐Excess Tearing / Watering
☐Eye Pain or Soreness
☐Mucous or Discharge
☐Inflammation of the Eyelid
☐Styes or Chalazia

Have you been diagnosed with any of the following ocular problems? **Check the box if "Yes."**

☐Cataracts
☐Crossed Eyes
☐Eye Injury
☐Glaucoma
☐Lazy Eye / Amblyopia
☐Macular Degeneration
☐Retinal Detachment / Disease
☐Dry Eye
☐Other _____

Medical History

List any medications that you are currently taking (include oral contraceptives, aspirin, etc):

_____

_____

_____

Are you allergic to any medications? ☐ No ☐ Yes If yes, which ones:_____

_____

REVIEW OF SYSTEMS Please check the box beside any problem you currently have, or have had, in the following areas or mark All Normal.

Allergic/Immunologic……☐All Normal
- ☐Allergy/Hay fever

Cardiovascular/Cardiac.…….☐All Normal
- ☐Arteriosclerosis
- ☐Heart Disease
- ☐High Blood Pressure
- ☐High Cholesterol

Constitutional…….☐All Normal
- ☐Fever
- ☐Weight Loss/Gain

Ears, Nose, Mouth, Throat.……☐All Normal
- ☐Sinus Congestion
- ☐Dry Throat/Mouth

Endocrine……☐All Normal
- ☐Diabetes
- ☐Thyroid Abnormalities
- ☐Chronic Fatigue

Gastrointestinal ……..☐All Normal
- ☐Diarrhea/Constipation
- ☐IBS/Crohn's Disease
- ☐Ulcers
- ☐Reflux

Hematologic/Lymphatic…….☐All Normal
- ☐Anemia
- ☐Bleeding Problems
- ☐Breast Cancer

Integumentary (Skin)……..☐All Normal
- ☐Cancer
- ☐Rashes
- ☐Easy Bruising

Musculoskeletal……..☐All Normal
- ☐Rheumatoid Arthritis
- ☐Muscle Pain
- ☐Joint Pain

Neurological……...☐All Normal
- ☐Migraines
- ☐Dizziness
- ☐Seizures
- ☐Stroke

Psychiatric……..☐All Normal
- ☐Anxiety
- ☐Depression
- ☐Memory Loss

Respiratory…….☐All Normal
- ☐Asthma

Social History

Do you use tobacco products? ☐No ☐ Yes If yes, type/amount/how long:_____

Are you pregnant or nursing? ☐No ☐ Yes ☐ N/A

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased)

	Relation to you		**Relation to you**
☐Glaucoma	_____	☐Diabetes	_____
☐Cataract	_____	☐Cancer	_____
☐Macular Degeneration	_____	☐Heart Disease	_____
☐Retinal Detachment	_____	☐High Blood Pressure	_____
☐Blindness	_____	☐Kidney Disease	_____
☐Crossed Eyes	_____	☐Lupus / Arthritis	_____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor or any other member of the staff responsible for any errors or omissions that I have made in the completion of this form**.**
I attest that the information I provided is true and correct to the best of my ability and knowledge.
Signature of Patient (*Parent or Guardian if minor*) _____Date _____
Printed name of signature above_____ Relationship to minor _____