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: ___________________________________
Who 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 is your present pair of lenses?_________________

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 Vision
☐Loss of Vision
☐Loss of Side Vision
☐Distorted Vision
☐Double Vision
☐Tired Eyes
☐Flashes/ Floaters
☐Halos/ Glare/ Light sensitivity
☐Dryness
☐Sandy or Gritty Feeling
☐Burning
☐Itching
☐Redness
☐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

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 __________________