PATIENT MEDICAL HISTORY QUESTIONNAIRE

PROFESSIONAL EYECARE

Patient Name:_____ **Date:**_____

Date of Birth:_____

EYE DISEASES	Yes	No	Explain
Amblyopia			
Blepharitis			
Blindness			
Cataracts			
Color Blindness			
Diabetic Retinopathy			
Dry Eye Syndrome			
Eye Injuries			
Glaucoma			
Glaucoma Suspect			
High Risk Medication			
Macular Degeneration			
Vitreal Detachment			
Retinal Detachment			
Strabismus			
Other			

Current Medications: _____

_____

_____

_____

_____

_____

Current Eye Drops: _____

_____

_____

_____

Allergies to Medications: _____

_____

_____

_____

CURRENT EYE SYMPTOMS	Yes	No	Explain
Asthenopic			
Glare Sensitivity			
Headaches			
Light Sensitivity			
Tired Eyes			
Physiologic			
Burning			
Dryness			
Tearing			
Eyelid Swelling			
Eye Pain or Soreness			
Foreign Body Sensation			
Infection of Eye Lid			
Itching			
Mucous			
Ptosis (drooping eye lid)			
Redness			
Sandy or Gritty Feeling			
Visual Symptoms			
Blurred Vision, Distance			
Blurred Vision, Near			
Distorted Vision			
Flashes of Lights			
Fluctuating Vision			
Loss of Central Vision			
Loss of Side Vision			
Loss of Vision			
Floaters			
Additional Notes			

Interested in LASIK? **Yes** ☐ **No** ☐

PATIENT MEDICAL HISTORY QUESTIONNAIRE

PROFESSIONAL EYECARE

REVIEW OF SYSTEMS

Constitutional	Yes	No	Explain
Fever			
Fatigue			
Other			
Ear, Nose, Throat, Mouth			
Hearing Loss			
Sinus Disorders			
Other			
Cardiovascular			
Atrial Fibrillation			
Heart Disease			
Hypertension			
Stroke/TIA			
Other			
Respiratory			
Asthma			
Emphysema/COPD			
Shortness of Breath			
Other			
Gastrointestinal			
Intestinal Conditions			
Other			
Urinary			
Flomax use			
Kidney Disease			
Urinary Conditions/Symptoms			
Other			
Musculoskeletal			
Arthritis			
Muscle/Joint/Back Pain			
Other			

Skin	Yes	No	Explain
Herpes			
Rash/Itching			
Rosacea			
Shingles			
Skin Cancer			
Other			
Neurological			
Multiple Sclerosis			
Frequent Headaches			
Convulsions/Seizures			
Other			
Psychiatric			
Memory Loss			
Depression			
Other			
Endocrine			
Diabetes			
Thyroid Disease			
Other			
Blood			
Anemia			
Cholesterol			
Other			
Allergic/Immunologic			
Seasonal Allergies			
Lupus			
Other			
Pregnant			
Nursing			
Other conditions			

PATIENT MEDICAL HISTORY QUESTIONNAIRE

PROFESSIONAL EYECARE

SOCIAL HISTORY- *GENERAL*

Current Occupation | Years | Employer

Do you drink alcohol? ○ No ○ Occasional ○ 1 per day ○ 2-3 per day ○ 4+ per day

Do you smoke? ○ No ○ Occasional ○ 1/2 pack per day ○ 1 pack per day ○ 1+ pack per day

Past smoker ○ Yes ○ No | When did you quit smoking? | Smoking status?

Tobacco use cessation intervention, counseling? ○ Yes ○ No

Do you chew tobacco? ○ Yes ○ No

Do you use illegal drugs? ○ Yes ○ No

Influenza Immunization ○ Recommended ○ Administered

Tobacco cessation pharmacologic therapy? ○ Yes ○ No

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Marital Status

SOCIAL HISTORY- *VISION*

Computer Used ○ Yes ○ No | Hours per day | Distance from computer

Do you drive? ○ Yes ○ No | Daily Mileage | Do you have visual difficulty when driving? ○ Yes ○ No

Do you have glare problem? ○ Yes ○ No | Do you have any problems with night vision? ○ Yes ○ No

SOCIAL HISTORY- *CONTACT LENSES*

Have you tried to wear contact lenses? ○ Yes ○ No | Reason for stopping

If not a contact lens wearer, are you interested in trying contact lenses at this time? ○ Yes ○ No

Do you currently wear contact lenses? ○ Yes ○ No | Since

Type and brand of contact lenses

How many hours/day? | How many days/week? | Today's wearing time?

What contact lens solution do you use? | Cleaner | Disinfectant | Enzyme

Please rate the following on a scale of 1-10, with 1 being POOR and 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort			Distance Vision			Near Vision		

SOCIAL HISTORY- *SPECTACLES*

Do you currently wear glasses? ○ Yes ○ No | Since | ☐ Full Time ☐ Part Time ☐ Distance ☐ Close

Glasses owned

☐ Single Vision ☐ Safety glasses ☐ Bifocals ☐ Sports glasses

☐ Trifocals ☐ Progressive ☐ Back-up glasses ☐ Other

Have you had trouble in the past with glasses? ○ Yes ○ No | If Yes, please explain

Do you wear sunglasses? ○ Yes ○ No | Are your sunglasses your current prescription? ○ Yes ○ No

Special Eyewear Needs

☐ Computer (special prescriptions, special anti-glare tints or coatings)

☐ Safety Glasses (gardening, woodworking, welding)

☐ Occupational (mechanics, plumbers, pilots)

☐ Sports/Hobbies (racquet sports, motorcycle)

Hobbies/Interests

PATIENT MEDICAL HISTORY QUESTIONNAIRE

PROFESSIONAL EYECARE

FAMILY HISTORY				
	Yes	No	Relationship to Patient	Other Notes
Eye Diseases				
Amblyopia (lazy eye)				
Blindness				
Cataracts				
Color Blindness				
Eye Tumors				
Glaucoma				
Glaucoma Suspect				
Macular Degeneration				
Retinal Detachment				
Strabismus (eye turn)				
Other Eye Conditions				
Systemic Diseases				
Arthritis				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Lupus				
Stroke				
Thyroid disease				
Other Diseases				
Additional notes				

How Did You Hear About Our Practice?_____