PATIENT HISTORY QUESTIONNAIRE

Name: ______________________________ Birth Date:___/___/___ Date: ___/___/______

PERSONAL EYE HISTORY

Last Eye Exam: ___/___/_______ By: _____________________

Age of glasses: _______________ Do you wear contact lenses?_________________________

Eye Medications: ____

Previous eye surgeries or injuries: ____

Previous or current eye diseases: ____

Do you have any of the following:

☐ Blurred vision	☐ Loss of vision	☐ Stinging, burning eyes
☐ Red/irritated eyes	☐ Tearing	☐ Eye discharge or crusting
☐ Itchy eyes	☐ Eye pain or ache	☐ Eye fatigue or strain
☐ Flashing lights	☐ Floaters (lines or spots)	☐ Double vision
☐ Glare in bright light	☐ Poor vision at night	☐ Amblyopia (lazy eye)
☐ Crossed or drifting eye	☐ Nystagmus (shaky eye)	☐ Other symptoms: _____________

PERSONAL MEDICAL HISTORY

Allergies: ____ ☐ None

Last medical exam: ___/___/______ Primary Care Physician: __________________________

Are you pregnant? Y N Are you nursing? Y N

Previous surgeries or major illnesses:____

Current medications (including over-the-counter): _____________________________________

Do you smoke? Y N Do you drink alcohol? Y N If yes, how much? ___________

Do you have problems with any of the following:

☐ Hearing	☐ Dizziness	☐ Headache/migraine
☐ Skin condition	☐ Heart condition	☐ High blood pressure
☐ Lung, breathing	☐ Gastrointestinal	☐ Diabetes
☐ Thyroid	☐ Arthritis	☐ Joint or back pain
☐ Reproductive system	☐ Urinary system	☐ Depression, anxiety
☐ Seasonal allergies	☐ Cancer	

☐ Other: ____

FAMILY HISTORY

Do any of your family members have (if yes, who?):

☐ Glaucoma ___________________	☐ Macular degeneration ______________________
☐ Diabetes ____________________	☐ Heart disease ____________________________
☐ Cancer ______________________	☐ High blood pressure _______________________

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