# Patient Questionnaire

Patient Name: ______________________ Date of Birth_________ Today's Date: _________

## Medical History

Name of Primary Doctor__________________
__________________Last Exam___/___/____

1. Do you take any medications (including over the counter, eye medications, and home/herbal remedies)
Yes No If YES, please explain:___________
_____________________________________

2. Do you have any drug or food allergies?
Yes No If YES, please explain:____________
_____________________________________

3. Have you ever had any surgery, major injuries and/or been hospitalized? Yes No
If YES, please explain:____________________
_____________________________________
_____________________________________
_____________________________________

4. If you are a female, are you currently pregnant and/or nursing? Yes No

## Review of Systems *Do you currently/have you ever had any problems in the following areas:*

Yes No

___ ___ Chronic fever, weight loss/gain, fatigue
___ ___ Skin problems, rashes, excessive dryness
___ ___ Hearing loss
___ ___ Sinus problems, allergies, sore throat
___ ___ Chest pain, irregular heart beat, high blood pressure
___ ___ Diabetes
___ ___ Shortness of breath, asthma, emphysema
___ ___ Headaches, migraines, seizures, numbness
___ ___ Kidney, bladder/urinary, genitals
___ ___ Heartburn, vomiting, abdominal pain
___ ___ Rheumatoid arthritis, muscle pain, joint pain
___ ___ Anemia, bleeding problems
___ ___ Thyroid, problems with other glands
___ ___ Depression, anxiety

*If you answered YES to any of the above or have a condition not listed, please explain and list medications/treatments:*

_____________________________________
_____________________________________
_____________________________________
_____________________________________
_____________________________________

## Ocular History

Last Eye Exam____/____/______

Do you wear glasses? Please circle:
Distance / Computer / Near
Full-time / Part-time

Do you wear contact lenses? YES NO
If yes, # of days per week__________
Brand________________________________

**What is the reason for your visit today?**

_____________________________________
_____________________________________

*Please give details on any YES answer below:*

YES NO

___ ___ History of Eye Injury______________
_____________________________________
___ ___ History of Eye Infection____________
_____________________________________
___ ___ History of Eye Disease_____________
_____________________________________
___ ___ History of a Crossed or Out-turned Eye__
_____________________________________
___ ___ History of Eye Surgery (include dates)___
_____________________________________

Do you have a family history of

| | | |
|---|---|---|
| Glaucoma? | ____Yes | ____No |
| Macular Degeneration? | ____Yes | ____No |
| Blindness? | ____Yes | ____No |
| Cataracts? | ____Yes | ____No |
| Crossed Eyes? | ____Yes | ____No |
| Retinal Detachment/Disease? | ____Yes | ____No |

**Sports/Hobbies** *Please circle anything you participate in regularly.*

| | | |
|---|---|---|
| Aerobics | Water Sports | Football |
| Basketball | Soccer | Woodworking |
| Hockey | Dancing | Biking |
| Jogging/Walking | Volleyball | Camping |
| Softball/Baseball | Racquetball | Hiking |
| Fishing | Sewing | Knitting |
| Painting | Shooting/Hunting | Tennis |
| Gardening | Crafts | Musical Instrument |
| Golf | Martial Arts | |

Other_________________________________