Health History Questionnaire

Name:_____ **DOB:**___/___/____

*Address :*_____

Phone: _____ *Email:*_____

Reason for visit: _____

_____

(*Check all that apply)*

Have you ever been diagnosed with the following conditions?

Condition	Y	N
Cataracts		
Age-related Macular Degeneration		
Glaucoma		
Diabetes		
Diabetic Retinopathy		
Dry Eye		
Eye Infection, inflammation or allergy		
Floaters and/or flashes of light		
Iritis or Uveitis		
Retinal defects or degenerations		
Lazy eye/ Amblyopia		
Other:		

Are you having any of the following vision concerns?

Concern	Y	N
Blurred Vision		
Eyestrain		
Eye Pain		
Severe Sensitivity to light		
Headache		
Poor night vision		
Bothersome night glare		
Double vision		
Total loss of vision		

Are you having any of the following eye concerns?

Concern	Y	N
Redness		
Burning		
Itching		
Tearing		
Discharge		
Other:		

Please tell us about your current corrective lenses.

Do you wear glasses?		
Do you wear contacts?		
What type of contacts? Dailies, 2 wk, monthly, Rigid gas permeable		
What brand of contacts?		

Do you use the computer ?		
Hours per day?		

Review of Systems (please circle those that apply)

System	
Constitutional	Fatigue, weight loss, Cancer
Ear, nose, throat	Hearing loss, sinusitis, dry mouth
Neurological	Multiple Sclerosis, Epilepsy, Cerebral Palsy, Tumor, Migraine, Autism
Psychiatric	Depression, Attention deficit, anxiety disorder, bipolar disorder
Cardiovascular	Hypertension, Stoke/ CVA, heart disease, Vascular disease, Congestive heart failure
Respiratory	Asthma, bronchitis, Emphysema, Chronic Obstruction, Sleep apnea
Gastrointestinal	Crohn's disease, colitis, ulcer, acid reflux, celiac disease
Genitourinary	Kidney disease, Prostate disease/cancer, STD, Pregnant, nursing
Musculoskeletal	Arthritis, Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis, Osteoporosis, Gout
Integumentary	Eczema, Rosascea, Psoriasis, Herpes Simplex, Herpes Zoster/Shingles
Endocrine	Type 2 Diabetes Mellitus, Type 1 Diabetes Mellitus, Thyroid, Hormonal dysfunction
Heme/ Lymph	Anemia, Hypercholesteremia
Allergy/Immune	Environmental allergies, Rheumatoid Arthritis, Lupus, Sjogren's syndrome

Please list all medications: (oral and/or eye drops)

Medication	Dosage	For

Allergies to medication

Social History

Current Occupation:
Hobbies:
Do you drink? Y / N If yes how much? ___/ wk
Do you smoke? Y / N If yes how much? ___/ day
Former smoker? Y/ N

Family History

Condition	Y	N	Who
Cancer type:			
Diabetes Mellitus			
Hypertension			
Hyperthyroid			
Hypothyroid			
Cataracts			
Macular Degeneration			
Glaucoma			