## Patient History Questionnaire

First Name: ______________________ MI: ________ Last Name: ______________________ DOB: ____________

| Major illnesses or injuries | Currently taking medications | For | Eye drops |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |
| | | | |

| Surgeries | Surgery Date | Surgeon |
| --- | --- | --- |
| | | |
| | | |
| | | |

**** DRUG ALLERGIES**** Yes No

Please List Them

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### YOUR EYE SYMPTOMS

| | Yes | No |
| --- | --- | --- |
| Glaucoma | | |
| Cataract | | |
| Macular degeneration | | |
| Retinal detachment | | |
| Color blindness | | |
| Blindness | | |
| Headaches | | |
| Tired eye / Eye strain | | |
| Lazy eye / Eye turn | | |
| Burning | | |
| Dryness | | |
| Excess tearing | | |
| Eye pain / Soreness | | |
| Foreign body feeling | | |
| Infection of eye | | |
| Itching | | |
| Mucous discharge | | |
| Droopy eyelid | | |
| Redness | | |
| Sandy or grittiness | | |
| Distorted vision | | |
| Floaters or spots | | |
| Fluctuating vision | | |
| Loss of vision | | |
| Loss of side vision | | |

### YOUR MEDICAL HISTORY

| | Yes | No |
| --- | --- | --- |
| Fever | | |
| Weight Loss | | |
| Ears, nose, throat | | |
| High blood pressure | | |
| Respiratory (asthma) | | |
| Gastrointestinal | | |
| Arthritis | | |
| Skin | | |
| Neurological | | |
| Anxiety / Depression | | |
| Diabetes | | |
| Thyroid | | |
| Blood / Lymph | | |
| Allergies / Hayfever | | |
| Cancer: Type | | |
| High cholesterol | | |
| Other: | | |

### YOUR SOCIAL HISTORY

| Do you use: | Yes | No |
| --- | --- | --- |
| **Tobacco products**<br>Amount:<br>How long: | | |
| **Alcohol**<br>Amount:<br>How long: | | |
| **Illegal Drugs**<br>Amount:<br>How long: | | |

### YOUR FAMILY HISTORY

| **Eye Diseases** | Yes | No |
| --- | --- | --- |
| Glaucoma | | |
| Cataract | | |
| Macular degeneration | | |
| Retinal detachment | | |
| Color blindness | | |
| Blindness | | |
| Lazy eye / Eye turn | | |
| Other: | | |

| **Systemic Diseases** | Yes | No |
| --- | --- | --- |
| Arthritis | | |
| Cancer | | |
| Diabetes | | |
| Heart disease | | |
| High blood pressure | | |
| Kidney disease | | |
| Lupus | | |
| Thyroid disease | | |
| Other: | | |

### WOMEN ONLY

| | Yes | No |
| --- | --- | --- |
| Are you pregnant?<br>Today's Date: | | |
| Are you nursing?<br>Today's Date: | | |

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

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