Patient Questionnaire

NAME _____ TODAY'S DATE _____

AGE _____ DATE OF BIRTH _____

OCCUPATION _____ RETIRED? _____

REASON FOR VISIT _____

PRIMARY CARE DOCTOR _____

Do you **currently** have any of the following?

	YES	NO
Reduced vision w/glasses	_____	_____
Double Vision	_____	_____
Eye pain	_____	_____
Eye redness	_____	_____
Eye discharge	_____	_____
Eye itching	_____	_____
Eye burning	_____	_____
Eye watering	_____	_____
Glare	_____	_____
Light sensitivity	_____	_____
Floating spot(s)	_____	_____
Flashes of Light	_____	_____

Do you have any of the following today?

	YES	NO
Cold sores/Blisters	_____	_____
Dry mouth	_____	_____
Headache	_____	_____
Chest Pain	_____	_____
Allergies	_____	_____
Trouble breathing	_____	_____
Pregnant	_____	_____

Eye Drops Used: _____
_____
_____
_____

Do you wear any of the following (Circle One)? **GLASSES** **CONTACT LENSES** **BOTH**

Have you **ever been told** you have any of the following?			
	YES	**NO**	**EXPLAIN**
Near-sighted (myopia) Glasses for distance			
Far-sighted (hyperopia) Glasses for reading			
Astigmatism			
Cataracts			
Keratoconus			
Glaucoma			
Macular Degeneration			
Dry Eyes			
Do any of you **blood relatives** have:			
Glaucoma			
Macular Degeneration			
Other eye disease			

Have you ever had any type of eye surgery such as (Cataract Surgery, LASIK or Laser Vision Correction) or any other eye disease? _____

Have you **ever** been told you have any of the following health conditions? Please check 'yes' even if you are currently on medication to control the condition.

Past Medical History

	YES	NO	EXPLAIN
Anxiety / Depression			
Arthritis			
Asthma			
Cancer (Type)			
COPD			
Ear / Nose/ Throat			
Elevated Cholesterol			
Diabetes (with or without insulin)			
GERD			
Gynecological / Urinary Conditions			
Hepatitis			
High Blood Pressure			
HIV / AIDS			
Hypothyroidism / Hyperthyroidism			
Immune Disorder			
Kidney Stones / Kidney Disease			
Lupus			
Lyme Disease			
Migraines / Cluster Headaches			
Skin Disorder			

Any other conditions / general surgeries: _____

Please list all current prescription and over-the-counter medications you take:

☐ **NONE**

Are you **allergic** to any medications or latex? _____

☐ **NKDA**

Smoking (Circle One): Never / Previous / Current

Do you drink alcohol? _____

Patient Name: _____ Date of Birth: _____