HEALTH HISTORY QUESTIONNAIRE

Your Primary Care Physician _____ Physician's Tel:_____

When was your last *Health* exam? _____ When was your last *Eye* exam?_____

What is the main reason for your visit today? _____

History of Major Illnesses/Injuries

History of Surgeries	Date	Surgeon
Eye:		
Other:		

Current Medications & Eyedrops	Reason for Taking
****DRUG ALLERGIES****	

Your Current Eye Symptoms	Yes	No
Glaucoma		
Cataract		
Macular degeneration		
Retinal detachment		
Color Blindness		
Headaches		
Glare/light sensitivity		
Tired eye		
Lazy eye		
Burning		
Dryness		
Excess tearing		
Eye pain or soreness		
Foreign body sensation		
Infection of eye		
Itching		
Mucous discharge		
Droopy eyelid		
Redness		
Sandy or gritty feeling		
Crossed eyes		
Blurred vision distance		
Blurred vision near		
Distorted Vision		
Double Vision		
Floaters or spots		
Fluctuating Vision		
Loss of Vision		
Loss of Side Vision		

Your Medical History	Yes	No
Allergies (seasonal)		
Excessive Weight Loss/Gain		
Ears, nose, throat		
High Blood Pressure		
High Cholesterol		
Asthma/Breathing Problems		
Stomach Problems		
Arthritis/Osteoporosis		
Skin (acne, rashes, etc.)		
MS/Seizures		
Anxiety, depression		
Kidney Problems		
Diabetes		
Thyroid Problems		
Anemia/Blood Disorders		
HIV/Herpes/Lyme		
Cancer: type:		
Other specify		
Are you pregnant/nursing?		

Your Family History **Eye Diseases**	Yes	No	Who
Lazy eye			
Eye tumor			
Blindness			
Cataract(s)			
Color Blindness			
Glaucoma			
Macular degeneration			
Retinal detachment			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Stroke			
Kidney Disease			
Lupus			
Thyroid Disease			
Other:			

Your Social History

Current Occupation:	
Computer Use? Y or N Hrs/Day:	Exercise? Y or N Times per Week:
Do you wear glasses? Y or N If Yes: Full time or Part time? Type of glasses owned:	Do you use vitamins? Y or N Drink Alcohol? Y or N Drinks per week:
Do you wear contacts? Y or N If yes: what type	Smoke? Y or N 1/2/Pk 1/Pk 1+/Pk Day/Week
Hobbies/Interests (Circle): Golf/Tennis/Baseball/Fishing/Hiking/Jogging/Other:	

Patient Signature: x_____ Print Name: _____ **Date:**_____

Date	Changes Y/N	PT Initial	Date	Changes Y/N	PT Initial	Date	Changes Y/N	PT Initial