PATIENT HISTORY QUESTIONNAIRE

Last name:	First name: MI:
	Activities (sailing, golf, etc.)
grade in school):	_ you enjoy:
Last eye exam:yrs ago	yrs ago Do you wear glasses?: Contact lenses?: SIT TODAY?
HAVE YOUR EYES BEEN BOTHERING YOU LAT IF YES, HOW?	TELY? Please circle yes (Y) or no (N): Y / N
(for example, have you had MORE sensitivity to sunlight, difficulty wi with vision for sports/hobbies, etc.)	with night vision or headlight glare, eyestrain while reading or using a computer, difficulty
Please circle yes (Y) or no (N) if YOU	Please circle yes (Y) or no (N) if ANYONE IN YOUR
have ever had any of the following:	FAMILY has ever had any of the following:
Y / N hypertension (high blood pressure)	Y / N hypertension (high blood pressure)
Y / N diabetes	Y / N diabetes
Y / N heart problems	Y / N heart problems
Y / N high cholesterol	Y / N migraine or other headaches
Y / N allergies	Y / N cataract
Y / N sinus problems	Y / N glaucoma (high eye pressure)
Y / N migraine or other headaches	Y / N a "lazy" or crossed eye
Y / N asthma	Y / N retinal tear or detachment
Y / N thyroid problem	Y / N macular degeneration
Y / N depression	
Y / N cataract	Y / N Do you have any allergy to medicines?
Y / N glaucoma (high eye pressure)	(list them here):
Y / N a "lazy" or crossed eye	
Y / N retinal tear or detachment	Y / N Do you take any medications?
Y / N macular degeneration	(list them here):
Y / N dry/irritated/itching eyes	
Y / N eye injury/surgery	
Y / N other problem:	
Y / N Do you use: tobacco	
Y / N Do you drink: alcohol	
Y / N Do you use: other substances	
Y / N Women only: are you pregnant?	
Dr.'s use: Date: By:	
Date: No changes Changes:	By:
	By:
	By:
	By:
Date: No changes Changes:	By:
Date: No changes Changes:	By:
	By:
Date: No changes Changes:	By:
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Date: No changes Changes:	By:
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