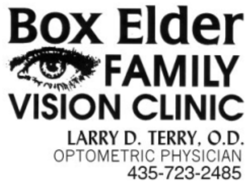

HEALTH HISTORY QUESTIONNAIRE

PATIENT (Full Legal Name): ____ **Date:** __________________
Date of Birth: _______________________

Primary Care Physician: ____________________________ **Telephone:** _____________________________

CURRENT MEDICATIONS

Drug Allergies: ____________________________Reaction: ____
Eye drops: ____
Non Rx Medications: ____

Prescription Medications	Reason Taken	Dosage	Frequency Taken	If no longer taken, date discontinued

SOCIAL HISTORY (circle as appropriate)

Occupation/ Employer: ____
Glasses Wearer: Yes/ No If yes: Full Time or Part Time
Contact Lens Wearer: Current Former No Prior Wear
Marital Status: Single Married Divorced Widowed
Do you drive: Yes/ No Computer Use Hours/Day ____________
***Smoking Status:** Never Smoked Former Smoker Every Day Smoker Someday Smoker
Alcohol Use: Yes/ No Recreational Drugs: Yes/ No
***Vital Signs:** Height _____ Weight _____ Blood Pressure ____/_____
Hobbies/ Interests: Golf/ Sports/ Fishing/ Hunting/ Hiking/ Jogging/ Computer/ Genealogy Other: ________________

SURGICAL HISTORY (include laser & eye surgeries) Approx. Year

_________________________________ ______________________
_________________________________ ______________________
_________________________________ ______________________
_________________________________ ______________________
_________________________________ ______________________
_________________________________ ______________________

PERSONAL PAST EYE HISTORY (circle all that apply):

Glaucoma Cataracts Crossed Eyes/ Lazy Eye Macular Degeneration Floaters Flashing Lights

Drooping eyelids Eye Infections

Eye Injuries (describe including dates): ____

____

Other: ____

PERSONAL MEDICAL HISTORY (circle all that apply/ brief description)

General Health (fever, weight loss, weight gain etc.): ____________________________________

Orthopedic (joint/ muscle problems, gout, arthritis etc.): __________________________________

Skin Problems (rash, cancer, acne, growths etc.): ______________________________________

Respiratory Issues (asthma, bronchitis, emphysema, COPD, CPAP use etc): ___________________

Allergy/ Ear-Nose-Throat Problems: ____

Blood/ Bleeding Disorders (high cholesterol/ triglycerides, leukemia, lymphoma etc.): ______________

Cancer (describe type,treatment & dates): ____

____

Diabetes (type and year of diagnosis): ____

Thyroid Problems: ____

Heart/ Vascular Problems: ____

High Blood Pressure:____

High Cholesterol/ Triglycerides: ____

Neurologic Problems (seizures, numbness, stroke, paralysis etc.): __________________________

____

Headaches (frequency/ type):____

Head or Spinal Injuries: ____

Stomach/ Digestive Problems (ulcers,acid reflux etc):_____________________________________

Genital/ Urinary Problems (HIV, hepatitis C, dialysis, kidney, syphilis, bladder issues etc.): ______________

____

Immune System Problems (HIV, Lupus, eczema etc.): ______________________________________

Psychiatric Problems (depression, anxiety, ADHD etc): ____________________________________

Other Items not included above: ____

FEMALES- Dates of most recent Pregnancy: ____

FAMILY HISTORY (circle all that apply; please indicate maternal or paternal- such as maternal grandfather):

Diabetes: ______________________

Cancer: ______________________

Lupus: ______________________

Multiple Sclerosis: ______________________

Heart Disease: ______________________

Stroke: ______________________

Retinal Detachment: ______________________

Cataract: ______________________

Lazy Eye/ Crossed Eyes: ______________________

Glaucoma: ______________________

Macular Degeneration: ______________________

Other: ______________________