Patient History Questionnaire

Patient name: _____
Date of birth: _____

Medications:
Please list any medications you take, if you have a list with you please provide that to our technicians and they will take a copy for you.

_____
_____
_____

Allergies:
___Seasonal/Environmental allergies _____
___Medication allergies _____
___Adhesive or medical dyes _____

Social History:
Do you smoke? Yes or No If yes, type and how long? _____
Do you drink alcohol? Yes or No If yes, how often? _____

Health History Review:
Do you or any family members have the following conditions?

	SELF	FAMILY	RELATIONSHIP
Glaucoma	_____	_____	_____
Macular Degeneration	_____	_____	_____
Cataract	_____	_____	_____
Lazy eye/amblyopia	_____	_____	_____
Retinal tear/detachment	_____	_____	_____
Other vision loss (please describe)	_____	_____	_____
Diabetes	_____	_____	_____
High Cholesterol	_____	_____	_____
High Blood Pressure	_____	_____	_____
Other (Please describe)	_____	_____	_____

Current Eye Symptoms:
Do you experience problems in the following areas with your eyes or vision?

Blurred Vision	_____			Light Sensitivity	_____
Double Vision	_____			Chronic infection	_____
Headaches	_____	Frequency	_____	Halos or glare	_____
Migraines	_____	Frequency	_____	Flashes or floaters	_____
Discharge	_____			Loss of side vision	_____
Dry eyes	_____			Night time driving	_____
Burning	_____			Other (please describe)	_____
Redness	_____			_____	
Excess Watering	_____			_____	