

**Today’s Date: \_\_\_\_\_\_\_\_\_**

**HEALTH HISTORY QUESTIONNAIRE**

All questions contained in this questionnaire are strictly confidential

and will become part of your medical record.

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| **Name:**Last ,First ,M.I. |
| **Date of Birth (DOB):** |  **M  F**  | **Age:** | **SS#:** |
| **Street** **Address:** | **Email:** |
| **City:** | **Zip:** | **Preferred Phone:** | **2nd Phone:** |
| **Employer:** | **How many hours do you use a computer a day? \_\_\_\_\_** |
| **Primary Care Physician:** | **Primary Care Physician’s Phone #** |
| ***Medical Insurance Company & ID:*** | ***Subscriber Name:*** |
| ***Vision Insurance Provider & ID:*** | ***Subscriber DOB: / /*** | ***SS#: -- --*** |
| ***Do you Require Referrals for specialist visits?*****Yes No Not Sure** | **Do you Have a health savings (HSA), or Flex Spending****(FSA) account? Yes No** |
| **Whom may we thank for referring you to our office?**(Friend, Internet, Employer, Other) |

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| **OCULAR HISTORY** |
| **Please indicate if you experience any of the following:** |

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| Blurry vision at distance *(if yes please specify*) N  Y \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Blurry vision while reading *(if yes please specify*) N  Y \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Redness N  Y \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dry/irritated eyes N  Y \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Excessive tearing N  Y \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Floating spots in your vision N  Y \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Itchy Eyes N  Y \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Eye pain N  Y \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Have *you* or anyone in your *immediate family* suffered from:**Glaucoma N  YMacular Degeneration N  YCataracts N  YLazy eye N  Y |
| **Continued on Back** |
| **Eyewear History:****Glasses** YNWorn:  Full time  Driving  ReadingSports/Other Hobbies (biking, fishing, hunting, swimming, music, reading, sewing) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Contacts** Y  N Number of hours worn per day: Frequency of replacement: daily  weekly  monthly |
| **SOCIAL HISTORY** |
| Do you drive?  Y  N Do you smoke?  Y  N Do you drink alcohol?  Often  Socially  Never |

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| **MEDICAL HISTORY** |
| **Check if you have or have had any symptoms in the following areas to a significant degree and briefly explain.** |
| Allergies/Immunologic (Seasonal allergies, RA, Lupus) |  Genitourinary (STD, HIV, Herpes) | Integumentary (Eczema, Rosacea, Skin cancer)  |
| Musculoskeltal (Fibromyalgia, Osteoarthritis) |  Psychiatric (Depression, Anxiety) | Other: |
|  Cardiovascular (High cholesterol, Hypertension) |  Ear, Nose & Throat (Sinusitis, Hearing loss) |  |
|  Gastrointestinal (Ulcer, Reflux) |  Hematologic/Lymphatic (Anemia, Leukemia) |  |
|  Neurological (MS, Stroke) |  Respiratory (Asthma, Emphysema) |  |
|  Recent illness within past month (Fever, Fatique, Weight loss) |  Endocrine (Diabetes, Thyroid) |  |
| **MEDICATIONS** |
| **List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** |
| Name the Drug | Strength | Frequency Taken |
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| **ALLERGIES TO MEDICATIONS** |
| Name of Drug | Reaction you had |
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**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Parent/Guardian Signature (if under 18)***

 1/27/2016