

**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  Y  Macular Degeneration N  Y  Cataracts N  Y  Lazy eye N  Y |
| **Continued on Back** |
| **Eyewear History:**  **Glasses** YNWorn:  Full time  Driving  Reading  Sports/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