Patient History Questionnaire

(must be updated each visit)

Name: _____ **DOB:** _____ Age: _____ Date: _____

address: _____ City: _____ State: ____ Zip: _____

SS#: _____ Home phone: _____ Work phone: _____

Parent or Guardian Name: _____ **Work phone:** _____

Email_____ Ok to receive email Y__ N__ Ok to receive text Y__ N____

Please list all the medications you are currently taking, including nonprescription medications, vitamins, and pain relievers.

_____

_____

_____

_____

Past, Family,Social History

Your Past/Present Eye History

Do you have or have you had any of the following:
Please circle yes or no.

Yes No **Diabetic Eye Disease**
Yes No Glaucoma
Yes No Macular Degeneration
Yes No Eye Surgery
Yes No Crossed Eye or Lazy Eye
Yes No Laser Surgery
Yes No Cataracts
Yes No Cataract Surgery
Yes No Ocular Trauma
Yes No Other: _____

Your Family Medical History

Have your parents, brothers, sisters and/or grandparents ever been affected by any of the following:
Please circle yes or no.

Yes No Diabetes
Yes No Macular Degeneration
Yes No Glaucoma
Yes No History of Crossed Eye or Lazy Eye
Yes No Retinal Detachment
Yes No Blindness
Yes No High Blood Pressure or Stroke
Yes No Vessel/Heart Disease
Yes No Bleeding or Blood Clotting Disorder
Yes No Kidney Disease
Yes No Cancer
Yes No Other: _____

Social History

Marital Status: M S D W (circle)
Are you employed? Yes No Retired _____
Drink Alcohol: _____ Drinks per Week
Caffeinated Beverages: _____Cups per Day
Do you smoke? Yes No
Recreational Drug Use: Yes No

Review of Systems

Do you have or have you had any of the following:
Please circle yes or no.

General/Constitutional

Yes No Recent, unexplained, Weight Loss/Gain
Yes No Past Surgeries
Yes No Tumor or Cancer
Current Height_____
Current Weight_____

Ears, Nose, Mouth, Throat

Yes No Ear, Nose, Mouth or **Throat Problems**

Heart/Vessels - Cardiovascular

Yes No High Blood Pressure
Yes No Stroke
Yes No Heart Problems

Breathing Respiratory

Yes No Breathing Problems, Sinus Problems
Yes No Asthma
Yes No TB (Tuberculosis)

Gastrointestinal

Yes No Stomach or Intestinal Problems
Yes No Hepatitis, Jaundice or Liver Problems

Genitourinary

Yes No Genital/Urinary Problems
Yes No Kidney Problems

Musculoskeletal

Yes No Arthritis/Bone or Joint Problems

Integumentary

Yes No Dermatological Problems
Yes No Skin Cancer

Neurological

Yes No Seizures/Nervous System Problems
Yes No Head Injury
Yes No Multiple Sclerosis

Psychiatric

Yes No Depression/Anxiety/Insomnia/Mental Illness

Endocrine

Yes No Thyroid Disease
Yes No Sugar Diabetes

Hematological/Lymph

Yes No Bleeding or Clotting disorders/Anemia
Yes No Cholesterol Problems

Allergic/Immunologic

Yes No Medication Allergies: _____
Yes No HIV/AIDS _____
Yes No Lupus/Sjogrens _____
Yes No Allergies/Hayfever _____

DR. DB JL PM

Examination: Patient:_____ DOB:_____ Date:_____

Sex: M F Last Exam:_____ Age:_____

Chief complaint:

HPI:
.Symptoms:
.Location:
.Quality:
.Severity:
.Duration:
.Timing:
.Context:
.Modifiers:

.Allergies:

.Medications:

.Ocular ROS:

.Medical Hx &ROS from ___/___/___reviewed: no changes
OD initials:_____

Head/Face nl / abnl Psych: Mood/Affect (anxiety/agitation/depression) nl Neuro: Oriented (person/place/time) y n

VA: SC< CC< PH< near< Glare<

K: OD_____ Old Rx OD_____ add_____
OS_____ OS_____ add_____

Static: OD_____20/ **Refraction:** OD _____20/ add_____
OS_____20/ OS _____20/ add_____
Phorias: distance_____ Near_____

CVF: Full(w/no quadrant defect) Failed Adnexa/Eyelids: nl Pupils: PERRLA NAPD Size____
Motility: Full Restricted CNP_____ Blepharitis OD OS OU
Cover Test: Far_____ Near_____ Meibomianitis OD OS OU
Color: AOC D-15 nl abnl Stereo: nl abnl #correct_____ Seconds_____

T ___/___@_____ (Method) NCT G Drops: 0.5% Prop 0.5% / 1% Tropic Paremyd 2.5%/10% Neo 5% Hom
Cyclopentolate Rev-eyes

Indent
20D
78D
90D
3 mirror
gonioprism
DO
MIO
Hruby

SLE:

OD			OS
nl	TBUT___	Tear Film	nl TBUT___
nl	arcus	Cornea	nl arcus
nl	pterygium		nl pterygium
nl	injection	Conj.	nl injection
nl	pinguecula		nl pinguecula
_____		AC	_____
nl	rubeosis	Iris	nl rubeosis
cl	NSC/PSC/Cort	Lens	cl NSC/PSC/Cort

Retina:

OD			OS
nl	drusen	Macula	nl drusen
nl	RPE chngs		nl RPE chngs
nl	HR/ASR	Vessels	nl HR/ASR
nl	PVD	Vitreous	nl PVD

Optic Discs: OD nl _____ size/appearance/NFL C/D OS nl _____

Diagnosis/Plan
Hyperopia
Myopia
Hyperopic Astig
Myopic Astig
Mixed Astig
Presbyopia

RTO:

_____OD