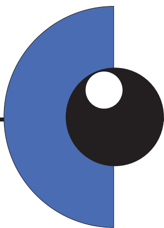

OPTOMETRIC CARE, INC. *Providing excellence in eyecare since 1940*

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Patient History Questionnaire

Name:________________________________ Birth Date : ____/____/____ Sex: M F

Street Address: __________________________________City/State/Zip :___________________________________

Home Phone: ( )_____________Cell Phone: ( )_____________Work phone : ( )_____________

SS# ______/______/______ Email :____________________________________

Do you have eye insurance? Yes No Name of insurance company:______________________________

Do you have medical insurance? Yes No Name of insurance company:______________________________

How did you learn of our office? ☐Relative ☐Friend ☐Insurance ☐Yellow Pages ☐Yellow Book ☐Website

Do you wear glasses? Yes No Contact Lenses? Yes No

Have you had eye surgery? Yes No What kind__________________________ Date____________

Have you had an eye injury? Yes No What kind__________________________ Date____________

Primary Care Physician:__________________________ Last visit with your PCP:______________

YOUR MEDICAL HISTORY Do you have or have you had in the past any of the following conditions:

High Blood Pressure	No	Yes	Diabetes	No	Yes
Cancer	No	Yes	Heart Disease	No	Yes
Thyroid Disease	No	Yes	Arthritis	No	Yes

List all medications that you currently take. (Include oral contraceptives, aspirin, over the counter medications and home remedies):

____

Are you pregnant, nursing and/or do you think you maybe pregnant? NO YES

List all major surgeries and/or hospitalizations you have had: ____

____

Are you allergic to any medications? No Yes If yes please list: ____

YOUR FAMILY HISTORY Do any of your blood relatives have the following conditions:

Crossed eyes	No	Yes	Diabetes	No	Yes
Lazy eye	No	Yes	Heart Disease	No	Yes
Macular degeneration	No	Yes	High Blood Pressure	No	Yes
Glaucoma	No	Yes	Cancer	No	Yes
Retinal detachment	No	Yes	Thyroid Disease	No	Yes

YOUR EYE HISTORY Do you have or have you had in the past any of the following conditions:

Crossed eyes	No	Yes	Glaucoma	No	Yes
Lazy eye	No	Yes	Retinal detachment	No	Yes
Macular degeneration	No	Yes	Cataract	No	Yes

YOUR SOCIAL HISTORY

Do you use tobacco products?	No	Yes	If yes, how many packs/cigars per day:
Do you drink alcohol?	No	Yes	If yes, how many drinks per day:

-------- OVER --------

Patient History Questionnaire Cont.

REVIEW OF SYSTEMS Do you currently have any of the problems listed below?

Eyes:

Loss of side vision	No	Yes
Blind spot in vision	No	Yes
Distorted vision/halos	No	Yes
Mucous discharge	No	Yes
Burning eyes	No	Yes
Dry eyes	No	Yes
Red eyes	No	Yes
Watering eyes	No	Yes
Itching	No	Yes
Light sensitivity	No	Yes
Flashes	No	Yes
Floaters	No	Yes
Double Vision	No	Yes

Constitutional

Recent fevers	No	Yes
Weight gain/loss	No	Yes

Neurological

Headaches	No	Yes
Numbness	No	Yes

Ears/Nose/Throat

Hearing loss	No	Yes
Sinus infection	No	Yes
Sore throat	No	Yes

Endocrine

Frequent urination	No	Yes
Frequent thirst	No	Yes

Respiratory

Sleep Apnea	No	Yes
Breathing difficulty	No	Yes
Chronic cough	No	Yes

Vascular/Cardiovascular

Chest pain	No	Yes
Irregular heart beat	No	Yes
Swelling of legs	No	Yes

Gastrointestinal

Gastric Reflex/Heartburn	No	Yes
Abdominal pain	No	Yes

Genitourinary

Crohn's Disease	No	Yes
Painful urination	No	Yes
Blood in urine	No	Yes

Bones/Joints/Muscles

Swollen joints	No	Yes
Joint pain	No	Yes
Muscle aches	No	Yes

Lymphatic/Hematologic

Anemia	No	Yes
Bleeding problems	No	Yes
Swollen glands	No	Yes

Psychiatric

Depression	No	Yes
Anxiety	No	Yes

Allergic/Immunologic

Autoimmune Disorders	No	Yes
Airborne allergies	No	Yes
Frequent infections	No	Yes

If you answered yes to any of the questions, please explain below:______________________________________

____

Patient or Parental Signature:____ Date:____/____/____