Patient History Questionnaire

When was your last eye exam? _____ Where? _____
Do you presently wear glasses? □ Yes □ No If yes, when do you wear them? _____
Do you presently wear contact lenses? □ Yes □ No
Which brand? _____What power? _____ Where do you buy them? _____

Please indicate your race:
□ American Indian or Alaskan Native
□ Asian
□ Black or African-American
□ Hispanic/ Latino
□ Native Hawaiian or Other Pacific Islander
□ Mixed
□ White/ Caucasian

What is your preferred language? □ English □ Spanish □ Other _____

Do you experience any of the following eye/vision problems? (Check all that apply and describe.)

□ Previous eye injury Describe: _____
□ Previous eye surgery Describe: _____
□ Blurry vision Describe: _____
□ Double vision Describe: _____
□ Excessive irritation/ pain Describe: _____
□ Eye discharge/ tearing Describe: _____
□ Flashes of light Describe: _____
□ Floaters Describe: _____
□ Loss of vision Describe: _____

Have you or anyone in your family ever been diagnosed with the following? (Check and explain who.)

□ Glaucoma _____ □ Cancer _____
□ Cataracts _____ □ Diabetes _____
□ Macular Degeneration _____ □ High Blood Pressure _____
□ Blindness _____ □ High Cholesterol _____
□ Retinal disorder(s) _____ □ Heart Disease _____

Describe any other eye/vision problems (other than glasses): _____
_____
_____

Describe any health problems other than those checked above: _____
_____

When was your last physical exam? _____ Who is your primary physician? _____
List your current medications and reason for taking?

1. _____
2. _____
3. _____

Are you allergic to any medication(s)? If so, which? _____
Do you have any other allergies? If so, please describe: _____

Are you pregnant? □ Yes □No If yes, how far along are you? _____