



# WOODBIDGE OPTOMETRY

## Patient History Questionnaire

Eye Examination Date:

\_\_\_\_/\_\_\_\_/\_\_\_\_

Full Name: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Driver's License #: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_

Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medical Insurance: \_\_\_\_\_

Previous Eye Doctor: \_\_\_\_\_

Last Eye Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Vision Insurance: \_\_\_\_ VSP \_\_\_\_ MES \_\_\_\_ EyeMed \_\_\_\_ Other \_\_\_\_\_

Responsible Party if different: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone: \_\_\_\_\_ Billing Address if different: \_\_\_\_\_

Who may we thank for referring you to our office: \_\_\_\_\_

**★ PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED ★**

### OCULAR HISTORY

Do you wear glasses?  No  Yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Do you wear contact lenses?  No  Yes If yes, what type?  Rigid  Soft  Toric  Multifocal  Monovision

Extended Wear Do you wear them  Full Time  Part Time How frequently do you replace them? \_\_\_\_\_

Have you had refractive surgery? \_\_\_\_\_ If yes, Date \_\_\_\_\_ Type \_\_\_\_\_

What other services would you like to be evaluated for?  Refractive Surgery  Contact Lenses

Computer Glasses  Reading Glasses  Sunglasses  Driving Glasses

Are you having any visual difficulties? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Are you currently experiencing any of the following problems with your eyes? **Check the box if "Yes."**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Blurred Vision      | <input type="checkbox"/> Flashes / Floaters in Vision      | <input type="checkbox"/> Redness                    |
| <input type="checkbox"/> Loss of Vision      | <input type="checkbox"/> Halos / Glare / Light Sensitivity | <input type="checkbox"/> Excess Tearing / Watering  |
| <input type="checkbox"/> Loss of Side Vision | <input type="checkbox"/> Dryness                           | <input type="checkbox"/> Eye Pain or Soreness       |
| <input type="checkbox"/> Distorted Vision    | <input type="checkbox"/> Sandy or Gritty Feeling           | <input type="checkbox"/> Mucous Discharge           |
| <input type="checkbox"/> Double Vision       | <input type="checkbox"/> Burning                           | <input type="checkbox"/> Inflammation of the Eyelid |
| <input type="checkbox"/> Tired Eyes          | <input type="checkbox"/> Itching                           | <input type="checkbox"/> Styes or Chalazion         |

Have you been diagnosed with any of the following ocular problems? **Check the box if "Yes."**

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Cataracts    | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Retinal Detachment / Disease |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Lazy Eye / Amblyopia | <input type="checkbox"/> Dry Eye                      |
| <input type="checkbox"/> Eye Injury   | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Other _____                  |

# MEDICAL HISTORY

List any medications you are currently taking (include oral contraceptives, aspirin, over the counter medications):

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Are you allergic to any medications?  No  Yes If yes, which ones: \_\_\_\_\_

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

**REVIEW OF SYSTEMS** Please check the box beside any problem you currently have, or have had, in the following areas:

**ALLERGIC / IMMUNOLOGIC**

Allergy / Hay Fever

All Normal

**CARDIOVASCULAR / CARDIAC**

- Arteriosclerosis
- Heart Disease
- High Blood Pressure
- High Cholesterol

All Normal

**CONSTITUTIONAL**

- Fever
- Weight Loss / Gain

All Normal

**EARS, NOSE, MOUTH, THROAT**

- Sinus Congestion
- Dry Throat / Mouth

All Normal

**ENDOCRINE**

- Diabetes
- Throid Disease
- Chronic Fatigue

All Normal

**GASTROINTESTINAL**

- Diarrhea / Constipation
- IBS / Crohn's Disease
- Ulcers
- Reflux

All Normal

**GENITOURINARY**

- Kidney Disease
- Ovarian / Uterine Cancer
- Prostate Cancer

All Normal

**HEMATOLOGIC / LYMPHATIC**

- Anemia
- Bleeding Problems
- Breast Cancer

All Normal

**INTEGUMENTARY (Skin)**

- Cancer
- Rashes
- Easy Bruising

All Normal

**MUSCULOSKELETAL**

- Rheumatoid Arthritis
- Muscle Pain
- Joint Pain

All Normal

**NEUROLOGICAL**

- Migraines
- Dizziness
- Seizures
- Stroke

All Normal

**PSYCHIATRIC**

- Anxiety
- Depression
- Memory Loss
- Hallucinations

All Normal

**RESPIRATORY**

- Asthma
- Bronchitis
- Emphysema
- Chronic Cough

All Normal

If you checked any of the above boxes or have a condition not listed, please explain further: \_\_\_\_\_

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Are you pregnant and / or nursing?  No  Yes

**FAMILY HISTORY** Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

	RELATION TO YOU		RELATION TO YOU
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Cataract	_____	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Macular Degeneration	_____	<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Retinal Detachment	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Blindness	_____	<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Crossed Eyes	_____	<input type="checkbox"/> Lupus / Arthritis	_____

Signature: \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_