HEALTH QUESTIONNAIRE

Name:_____ SSN#_____ DOB:_____

Home Address:_____ Phone #:_____

E-mail:_____ Primary Doctor:_____ Pharmacy:_____

Ethnicity: ☐Hispanic/Latino ☐**Not** Hispanic/Latino

Race: ☐American Indian ☐Alaska Native ☐Asian ☐African American ☐Native Hawaiian/ Pacific Islander ☐White ☐Other

What is today's reason for your visit?_____

Personal Ocular History

Are you NOW experiencing any of the following? ***Please check all that apply.***

☐ Flashes ☐ Floaters ☐Tearing ☐ Double Vision ☐Loss of Vision ☐Loss of Sharpness ☐Headaches
☐Light Sensitivity ☐Pain ☐Red ☐Burning ☐Itching ☐ **NONE OF THE ABOVE**

In the PAST, have you had any of the following problems with your eyes? ***Please check all that apply.***

☐ Glaucoma ☐ Cataract ☐ Injury ☐Surgery ☐ Lazy Eye ☐ Crossed Eyes ☐ Dry Eye ☐ Nystagmus
☐ Age Related Macular Degeneration ☐ Inflammatory Disorder ☐ Retinal Hole ☐ Retinal Degeneration
☐ Keratoconus ☐ Patching ☐ Strabismus ☐ Nystagmus ☐ Amblyopia ☐ **NONE OF THE ABOVE**

Social History

Any use of alcohol? **Y**☐ / **N**☐ If **YES,** Amount_____ ☐ Daily ☐Weekly ☐Monthly

Any current tobacco use? **Y**☐ / **N**☐ If **YES**, how many daily?_____

Previous Smoker? **Y**☐ / **N**☐

Employer:_____ Occupation:_____

Student/ Grade:_____ Hobbies:_____

Family Medical / Ocular History

Do any of these Medical condition(s) run in your family? *Please check all that apply and identify family member.*

Cancer	**Y**☐ / **N**☐	If **YES**, who of the following? Mother ☐ Father ☐ Brother ☐ Sister ☐
Diabetes	**Y**☐ / **N**☐	If **YES**, who of the following? Mother ☐ Father ☐ Brother ☐ Sister ☐
High Blood Pressure	**Y**☐ / **N**☐	If **YES**, who of the following? Mother ☐ Father ☐ Brother ☐ Sister ☐
Thyroid	**Y**☐ / **N**☐	If **YES**, who of the following? Mother ☐ Father ☐ Brother ☐ Sister ☐

Do any of the eye condition(s) listed run in your family? *Please check all that apply and identify family member.*

Cataracts	**Y**☐ / **N**☐	If **YES**, who of the following? Mother ☐ Father ☐ Brother ☐ Sister ☐
Macular Degeneration	**Y**☐ / **N**☐	If **YES**, who of the following? Mother ☐ Father ☐ Brother ☐ Sister ☐
Glaucoma	**Y**☐ / **N**☐	If **YES**, who of the following? Mother ☐ Father ☐ Brother ☐ Sister ☐

Personal Medical Health

General Health: □ Developmental Disabilities
□Fatigue Syndrome □ Cancer

Ear, Nose, Throat: □Hearing Loss □Dry Mouth
□Sinusitis □Laryngitis

Neurological: □Stroke/CVA □Tumor □Migraine
□Multiple Sclerosis □Cerebral Palsy □Epilepsy

Psychological: □Depression □ Attention Deficit
□ Anxiety □Bipolar

Cardiovascular:□ High Blood Pressure □Stroke/CVA
□Heart Disease □Vascular Disease □Heart Failure

Respiratory: □Bronchitis □Emphysema □Asthma
□Sleep Apnea □Smoker □Chronic Obstruction

Allergic/ Immunologic: □Drug Allergy □Lupus
□Environment Allergies □Rheumatoid Arthritis
□Sjogren's syndrome

Gastrointestinal:□ Crohn's □Colitis □Ulcer
□ Acid Reflux □ Celiac Disease

Genitourinary: □ Kidney Disease □Prostate disease/cancer
□Pregnant □Nursing □STD-herpetic/Chlamydia □Herpes

Musculoskeletal: □ Osteoarthritis □Gout □Arthritis
□Ankylosing Spondylitis □Fibromyalgia □Osteoporosis
□Muscular Dystrophy

Integument (Skin): □Eczema □ Rosacea □Psoriasis
□Herpes Simplex/ Cold Sores □ Zoster/ Shingles

Endocrine (Hormone): □ Type 2 Diabetes □Thyroid
□Type 1 Diabetes □Hormone Dysfunction

Blood/ Lymphatic: □Cholesterol □Anemia □Ulcer
□Large Volume Blood Loss

NONE OF THE ABOVE □

Please List Below any Medications/Supplements that you are currently taking.

Medication: Reason:

_____

_____

_____

_____

_____

Do you have any allergies to any medications? Please List:

_____

Do you have any other allergies? (ex. dust, pollen, food, ragweed,hayfever,bees …etc.) Please List:

_____

Latex Sensitivity? YES□ / NO□