FocusFamily
Eye Care

Patient History Questionnaire

Patient name:_____
Patient DOB: _____
Email address:_____
Primary Care Physician: _____
Office & Location: _____
Pharmacy:_____
Emergency Contact Name & Phone: _____

How did you hear about us:
___ Insurance Listing ___ Google/Internet Search ___Social Media ___Friend of family member
___ Other: _____ name_____

Employment or Student Status

___ Employed Full Time ___ Employed Part Time ___ Student Full Time ___Student Part Time
___ Not Employed ___ Retired ___ Active Military ___ Disabled

When was your last eye exam _____ **Who was your previous eye doctor?**_____

Do you wear glasses? (circle) YES NO

Do you wear contact lenses (circle) YES NO

Are you interested in a prescription for contact lenses? (circle) YES NO

Do you sleep in your contact lenses? (circle) YES NO

How often do you replace your contact lenses? _____

Medications:
Please list any medications you take, if you have a list with you we can take a copy for you
_____ _____
_____ _____
_____ _____

Allergies:
___Seasonal/Environmental allergies _____
___Medication allergies _____
___Adhesive, Latex or medical dyes _____
___ Other: _____

Social History:
Do you smoke? Yes or No If yes, type and how long? _____
Do you drink alcohol? Yes or No If yes, how often? _____

PLEASE TURN OVER AND COMPLETE

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Health History Review: Do you have the following conditions?

CONSTITUTION

__ Developmental Disabilities
__ Cancer (currently)
__ Type: _____

ENT

__ Hearing loss
__ Sinusitis
__ Dry Mouth
__ Laryngitis
__ Other_____

NEURO

__ Multiple Sclerosis
__ Epilepsy
__ Cerebral Palsy
__ Migraine
__ Stroke/CVA
__ Autism Spectrum Disorder
__ Other_____

CARDIOVASCULAR

__ High Blood Pressure
__ High Cholesterol
__ Congestive Heart Failure
__ Heart Disease
__ Other_____

RESPIRATORY

__ Asthma
__ COPD
__ Emphysema
__ Bronchitis
__ Sleep Apnea
__ Other_____

GI

__ Crohn's
__ Gastric Colitis
__ Acid Refulx
__ Celiac
__ Ulcer
__ Other_____

GU

__ Kidney Disease
__ Prostate Disease/Cancer
__ Benign Prostate Hypertrophy
__ STD: _____
__ Other ____

MUSCULOSKELETAL

__ Osteoarthritis
__ Osteoporosis
__ Fibromyalgia
__ Muscular Dystrophy
__ Ankylosing Spondylitis
__ Gout
__ Other _____

INTEGUMENTARY

__ Eczema
__ Rosacea
__ Psoriasis
__ Herpes Simplex/Cold sores
__ Herpes Zoster/Shingles
__ Other_____

ENDOCRINE

__ Type 1 Diabetes
__ Type 2 Diabetes
__ Gestational Diabetes
__ Thyroid Disorder
__ Grave's Disease
__ Hormonal Dysfunction
__ Other _____

HEME/LYMPH

__ Anemia
__ Large Volume Blood Loss
__ Blood Clotting Disorder __ Lupus
__ Other _____

ALLERGY/IMMUNOLOGY

__ Environmental Allergy
__ Rheumatoid Arthritis
__ Sjogren's Syndrome
__ Other_____

Family History: SELF/ FAMILY RELATIONSHIP

CONDITIONS

Do you or a member of your family have any of the following conditions?

Glaucoma _____ _____
Macular Degeneration _____ _____
Cataract _____ _____
Lazy eye/amblyopia _____ _____
Retinal tear/detachment _____ _____
Other vision loss (describe) _____ _____
Diabetes _____ _____
High Cholesterol _____ _____
High Blood Pressure _____ _____

CURRENT EYE

Do you experience any of the following symptoms?

__ Blurred Vision __ Double Vision
__ Headaches/ Migraines, Frequency____
__ Light Sensitivity __ Chronic Infection
__ Discharge __ Dry Eyes
__ Burning __ Red Eyes
__ Excessive Watering __ Halos/Glare
__ Flashes of Light __ Floaters
__ Night time driving problems
__ Other (Describe) _____

PLEASE TURN OVER AND COMPLETE