Patient Information

Patient Name _____ _____ _____
First Name Middle Initial Last Name

Date of Birth _____ Email Address: _____
☐ I do not have an email account

Gender: ☐ Male ☐ Female ☐ Other

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

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Who shall we contact in case of an emergency?

First Name _____ Last Name _____

Home Phone (_____) _____ Relationship: ☐ Single ☐ Married ☐ Widowed ☐ Separated

Work Phone (_____) _____ Cell Phone (_____) _____

Eye Surgeries

- IF YOU HAVE EVER HAD AN OPERATION ON YOUR EYES, PLEASE FILL OUT ALL OF THE REQUESTED INFORMATION.
- IF YOU HAVE HAD NO EYE SURGERIES, SELECT "NONE" IN THE 'NAME OF PROCEDURE BOX."

Date of Surgery _____ Surgeon _____

Name of Procedure:

☐ Cataract surgery
☐ Comeal Foreign Body
☐ Corneal Transplant
☐ Eye Muscle or Strabismus Surgery
☐ Eyelash Removal
☐ Retinal Detachment
☐ Eyelid Surgery
☐ Glaucoma Surgery
☐ Laser treatment of retina
☐ LASIK
☐ None
☐ Punctal Plugs
☐ RK

Family History

DO ANY OF YOUR FAMILY MEMBERS HAVE ANY OF THE CONDITIONS LISTED BELOW?
IF YES, CHECK ALL THAT APPLY:

	Sister	Mother	Father	Brother	Paternal Grandmother	Martial Grandmother	Paternal Grandmother	Maternal Grandmother
Family History of Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐	☐
Eye Injury	☐	☐	☐	☐	☐	☐	☐	☐
Retina Disease	☐	☐	☐	☐	☐	☐	☐	☐
Other Eye Disease	☐	☐	☐	☐	☐	☐	☐	☐
Strabismus	☐	☐	☐	☐	☐	☐	☐	☐
Amblyopia	☐	☐	☐	☐	☐	☐	☐	☐
Blindness/ Vision Loss	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐

OTHER FAMILY HISTORY _____

_____

Questionnaire

Choose the appropriate age

☐ I am 13 years old or younger

☐ I am 14 years old or older

Health History

ENDOCRINE

Thyroid Disorder	☐ Yes	☐ No	Female hormone replacement therapy	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Male hormone replacement therapy	☐ Yes	☐ No
Adrenal Disorder	☐ Yes	☐ No			

Other:

HEMATOLOGIC / LYMPHATIC

Anemia	☐ Yes	☐ No	Lymphoma	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No	Other Blood Disorders	☐ Yes	☐ No

Other:

CARDIOVASCULAR / HEART

Arrythmia / Irregular heart beat / palpitation	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Dysautonomia / POTS	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Syncope / Fainting	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Valve Replacement	☐ Yes	☐ No

Other:

NEUROLOGICAL

Cranial Nerve Palsy	☐ Yes	☐ No	Migraines	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No	Severe Headaches that aren't Migraines	☐ Yes	☐ No
Epilepsy / Seizures	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Feeling Uncoordinated	☐ Yes	☐ No	Vertigo	☐ Yes	☐ No

Other:

DOUBLE VISION ☐ Yes ☐ No

If yes, please answer the below questions:

1. Only at Near	☐ Yes	☐ No	2. Vertical	☐ Yes	☐ No
Only at Far	☐ Yes	☐ No	Horizontal	☐ Yes	☐ No
Both	☐ Yes	☐ No	Diagonal	☐ Yes	☐ No

EARS, NOSE AND THROAT

Benign Positional Vertigo / BPV / BPPV	☐ Yes	☐ No	Sensation of fluid leaking from Left ear	☐ Yes	☐ No
Fullness Left ear	☐ Yes	☐ No	Sensation of fluid leaking from Right ear	☐ Yes	☐ No
Fullness Right ear	☐ Yes	☐ No	Sinus Disorders	☐ Yes	☐ No
Meniere's Disease	☐ Yes	☐ No	Sinus Pain / Pressure	☐ Yes	☐ No
Ringing / Tinnitus in Left ear	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Ringing / Tinnitus in Right ear	☐ Yes	☐ No	TMJ problem	☐ Yes	☐ No

Other:

RESPIRATORY / LUNGS:

Asthma	☐ Yes	☐ No	Sarcoid	☐ Yes	☐ No
COPD	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No			

Other:

STOMACH / INTESTINES:

				☐ Yes	☐ No
Crohn's Disease	☐ Yes	☐ No	Ulcerative Colitis		
Irritable Bowel Syndrome	☐ Yes	☐ No	Diarrhea		
Nausea	☐ Yes	☐ No			

Other:

INTEGUMENT / SKIN

Skin Rash	☐ Yes	☐ No	Excessive Sweating	☐ Yes	☐ No
Eczema	☐ Yes	☐ No			

Other:

BONES / JOINTS / MUSCLES

Rheumatoid Arthritis	☐ Yes	☐ No	Cerebral Palsy	☐ Yes	☐ No
Polymyalgia	☐ Yes	☐ No	Neck Pain	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No	C-spine Fracture	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	C-spine Fusion	☐ Yes	☐ No

Other:

ALLERGIC / IMMUNOLOGIC

Seasonal Allergies	☐ Yes	☐ No	Anaphylactic Reactions	☐ Yes	☐ No
HIV	☐ Yes	☐ No			

Other:

PSYCHIATRIC

Depression	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Panic episodes	☐ Yes	☐ No	Agoraphobia	☐ Yes	☐ No
PTSD (Post Traumatic Stress Disorder)	☐ Yes	☐ No	ADD / ADHD (Attention Deficit Disorder/ Attention Deficit Hyperactivity Disorder)	☐ Yes	☐ No

Other:

GENITALS / KIDNEY / BLADDER

Frequent Urination	☐ Yes	☐ No	Kidney Transplant	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No			

Other:

CONSTITUTION

Fatigue	☐ Yes	☐ No	Chills	☐ Yes	☐ No
Fever	☐ Yes	☐ No	Insomnia	☐ Yes	☐ No

Other:

History of Cancer ☐ Yes ☐ No

If YES, list what kind(s):

Social History

Are you or have you been a smoker? ☐ Yes ☐ No

Check one:

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker

Do you drink alcohol? ☐ Yes ☐ No

Check one:

- ☐ Social drinker
- ☐ Light drinker - 1-2u/day
- ☐ Moderate drinker - 3-6u/day
- ☐ Heavy drinker - 7-9u/day

Do you misuse/abuse drugs or medications? ☐ Yes ☐ No

Check all that apply:

☐ Recreational drug user	☐ Crack	☐ Methamphetamine
☐ Cannabis	☐ Heroin	☐ Oxycontin
☐ Cocaine	☐ LSD	☐ Speed

Other: _____

Occupation or Grade in school _____

Hobbies _____

_____

_____

_____

General History

Last Eye Exam _____ (MM/DD/YYYY) **Dr Last Eye Exam** _____

DO YOU WEAR GLASSES?

☐ Yes ☐ No

If yes, please answer the below questions:

Age when glasses were first worn (in years): _____

Worn full or part time? (choose one):

Full Time	☐ Yes	☐ No
Part Time	☐ Yes	☐ No

Worn for far, near or both? (choose one):

Far Vision Only	☐ Yes	☐ No
Near Vision Only	☐ Yes	☐ No
Both Far and Near	☐ Yes	☐ No

DO YOU WEAR CONTACT LENSES?

☐ Yes ☐ No

If yes, please answer the below questions:

Age when contacts first worn (in years): _____

Worn full time or part time? (choose one):

Full Time	☐ Yes	☐ No
Part Time	☐ Yes	☐ No

DO YOU WORK AT A DESK OR ON A COMPUTER?

☐ Yes ☐ No

If yes, please answer the below questions:

Approximate distance from your eyes to the desk / computer screen (in inches): _____

How many hours per day? _____

Are glasses worn? ☐ Yes ☐ No

DO YOU PERFORM DISTANCE VIEWING (10 FEET AND BEYOND - CLASSROOM, WORK, DRIVING)?

☐ Yes ☐ No

If yes, please answer the below questions:

How many hours per day? _____

Are glasses worn? ☐ Yes ☐ No

DIAGNOSIS OF AMBLYOPIA?

☐ Yes ☐ No

If yes, Check all that apply:

- ☐ Both Eyes
- ☐ One Eye
- ☐ Treatment Management: Eye Muscle Surgery
- ☐ Treatment Management: Glasses
- ☐ Treatment Management: Patching
- ☐ Treatment Management: Pharmaceutical
- ☐ Treatment Management: Vision Therapy

DO YOU HAVE OCULAR COMPLICATIONS RELATED TO DIABETES?

☐ Yes ☐ No

DIAGNOSIS OF DRY EYE?

☐ Yes ☐ No

If yes, Check your level of severity:

- ☐ Mild
- ☐ Moderate
- ☐ Severe

OTHER VISION SYMPTOMS

Eye itchiness	☐ Yes	☐ No	Flashes of light	☐ Yes	☐ No
Spuls / Floalers	☐ Yes	☐ No	Sudden loss of vision	☐ Yes	☐ No
Eye Dryness	☐ Yes	☐ No	Increased tearing	☐ Yes	☐ No
Gritty feeling in eyes	☐ Yes	☐ No	Redness	☐ Yes	☐ No
Watery eye	☐ Yes	☐ No	Trouble seeing at night	☐ Yes	☐ No
Burning eyes	☐ Yes	☐ No	Trouble working up close	☐ Yes	☐ No
Eye strain	☐ Yes	☐ No	Trouble being fit with, or adjusting to a prior pair of glasses	☐ Yes	☐ No
Sore eyes	☐ Yes	☐ No			

READING

Trouble learning at school, work or other activity ☐ Yes ☐ No

Trouble concentrating ☐ Yes ☐ No

Other Questions

HAVE YOU BEEN DIAGNOSED WITH A TRAUMATIC BRAIN INJURY (TBI)? ☐ Yes ☐ No

If yes, please answer the below questions:

Who diagnosed you as having a TBI? _____

When did the TBI occur? Date: _____

Are you coming to Vision Specialists to be evaluated for symptoms that seem to have been caused by or seem to be related to TBI?

☐ Yes ☐ No

If headaches are a problem for you, please list your 3 worst headache triggers:

1. _____ 2. _____ 3. _____

If dizziness is a problem for you, please list your 3 worst dizziness triggers:

1. _____ 2. _____ 3. _____

Are you currently driving a car during the day? ☐ Yes ☐ No

Are you currently driving a car at night? ☐ Yes ☐ No

1. OF ALL OF YOUR SYMPTOMS, CHECK THE SYMPTOM THAT IS THE WORST AND CAUSES YOU THE MOST PROBLEMS:

- ☐ Dizziness
- ☐ Headache
- ☐ Anxiety
- ☐ Neck Pain / Ache
- ☐ Reading

2. HOW LONG HAVE YOU HAD THIS WORSTSYMPTOM? (IN YEARS)_____

3. HOW SEVERE IS YOUR WORST SYMPTOM, ON AN AVERAGE DAY, ON A 0-10 SCALE (WHERE 0 IS NO SYMPTOM AND 10 IS THE WORST IT COULD BE)?

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

4. OF ALL OF YOUR SYMPTOMS, CHECK THE SYMPTOM THAT IS THE SECOND WORST:

- ☐ Dizziness
- ☐ Headache
- ☐ Anxiety
- ☐ Neck Pain / Ache
- ☐ Reading

5. HOW LONG HAVE YOU HAD THIS SECOND WORST SYMPTOM (IN YEARS)_____

6. HOW SEVERE IS YOUR SECOND WORST SYMPTOM, ON AN AVERAGE DAY, ON A 0-10 SCALE (WHERE 0 IS NO SYMPTOM AND 10 IS THE WORST IT COULD BE)?

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

7. PLEASE ANSWER WHETHER YOU HAVE HAD ANY OF THESE TESTS PERFORMED:

Head CT	☐ Yes	☐ No	Electronystagmogram (ENG)	☐ Yes	☐ No
MRI/MRA	☐ Yes	☐ No	Other	☐ Yes	☐ No
Audiogram	☐ Yes	☐ No			

If Other list here:_____

_____

8. PLEASE ANSWER WHETHER YOU HAVE SEEN ANY DOCTORS / SPECIALISTS / OTHER PROVIDERS FOR THESE SYMPTOMS?

Internist	☐ Yes	☐ No	Reading Specialist	☐ Yes	☐ No
ENT (Ears / Nose /Throat)	☐ Yes	☐ No	Psychiatrist / Psychologist	☐ Yes	☐ No
Chiropractor	☐ Yes	☐ No	Pediatrician	☐ Yes	☐ No
Family Practice	☐ Yes	☐ No	Ophthalmologist	☐ Yes	☐ No
Neurologist	☐ Yes	☐ No	Optometrist	☐ Yes	☐ No
PM&R (Physical Medicine and Rehab.)	☐ Yes	☐ No	Emergency Physician / ER	☐ Yes	☐ No

If Other list here: _____

_____

Personal Medication List

Prescription Medications	Purpose or Reason Taken	Dose	Time(s) of Day	Form (Liquid, capsule, tablet)	Special Instructions

Over-the-Counter Medications	Purpose or Reason Taken	Dose	Time(s) of Day	Form (Liquid, capsule, tablet)	Special Instructions

Health Problems _____

Primary Doctor _____ **Doctor's Phone** _____

Local Pharmacy _____ **Pharmacy Phone** _____

Drug Allergies _____ **Your Phone** _____

Your Name _____ **Date** _____

Adapted by the American Society of Consultant Pharmacists (ASCP) Foundation
for the Center for Medicines & Healthy Aging