All About Eyes Optometry

Patient History Questionnaire

First Name:	MI:	Last Name:	DOB:

Major illnesses or injuries	Currently taking medications	For	Eye drops

Surgeries	Surgery Date	Surgeon

**** DRUG ALLERGIES****

☐ YES NO ☐

Please List Them

YOUR EYE SYMPTOMS

	Yes	No
Glaucoma		
Cataract		
Macular degeneration		
Retinal detachment		
Color blindness		
Blindness		
Headaches		
Tired eye / Eye strain		
Lazy eye / Eye turn		
Burning		
Dryness		
Excess tearing		
Eye pain / Soreness		
Foreign body feeling		
Infection of eye		
Itching		
Mucous discharge		
Droopy eyelid		
Redness		
Sandy or grittiness		
Distorted vision		
Double vision		
Floaters or spots		
Fluctuating vision		
Loss of vision		
Loss of side vision		

YOUR MEDICAL HISTORY

	Yes	No
Fever		
Weight Loss		
Ears, nose, throat		
High blood pressure		
Respiratory (asthma)		
Gastrointestinal		
Arthritis		
Skin		
Neurological		
Anxiety / Depression		
Diabetes		
Thyroid		
Blood / Lymph		
Allergies / Hayfever		
Cancer: Type:		
High cholesterol		
Other:		

YOUR SOCIAL HISTORY

Do you use:	Yes	No
Tobacco products Amount: How long:		
Alcohol Amount: How long:		
Illegal drugs Amount: How long:		

YOUR FAMILY HISTORY

Eye Diseases	Yes	No
Glaucoma		
Cataract		
Macular degeneration		
Retinal detachment		
Color blindness		
Blindness		
Lazy eye / Eye turn		
Other:		

Systemic Diseases	Yes	No
Arthritis		
Cancer		
Diabetes		
Heart disease		
High blood pressure		
Kidney disease		
Lupus		
Thyroid disease		
Other:		

WOMEN ONLY

	Yes	No
Are you pregnant? Today's Date:		
Are you nursing? Today's Date:		

If you answered YES to any of the above or have a condition not listed, please explain & list medications:
