Personal Health Questionnaire

ballard OPTICAL

Name_____ DOB _____ Date_____

What is the purpose of today's exam (i.e. blurry vision, eye pain, red eyes, trouble reading, headaches)?

_____

Date of last eye exam: _____ Location: _____

Are you interested in: Glasses Y / N Contact Lenses Y / N Non-surgical vision correction Y / N

Do you wear: Glasses Y / N Contact Lenses Y / N Any problems? _____

Have you ever had any eye surgeries or been prescribed medicine for your eyes? Y / N If yes, please explain.

_____

Are you currently experiencing any of the following? (circle all that apply) blurry vision, red eyes, itchy eyes, double vision, eye fatigue, watery eyes, dry eyes, floaters/flashes in vision, other eye-related symptoms (please list)

_____

What medications do you currently take? _____
Are you allergic to any medicine? If yes, please list. _____
Name of primary care doctor: _____ Clinic/city: _____

Have **you** or any **family members** ever been diagnosed with any of the following medical problems?

You	Family
High blood pressure Y / N (controlled y / n)	High blood pressure Y / N
High cholesterol Y / N (controlled y / n)	High cholesterol Y / N
Heart disease Y / N	Heart disease Y / N
Stroke Y / N	Stroke Y / N
Diabetes Y / N (controlled y / n)	Diabetes Y / N
Retinal detachment Y / N	Retinal detachment Y / N
Glaucoma Y / N (controlled y / n)	Strabismus/lazy eye Y / N
Strabismus/lazy eye Y / N	Glaucoma Y / N
Thyroid dysfunction Y / N	Thyroid dysfunction Y / N

Please circle any of the following symptoms or conditions that you have experienced in the last 3 months:

Constitutional: unexplained weight loss, fatigue, fever, appetite changes, **none**
Cardiovascular: chest pain, shortness of breath, swelling, **none**
Ears/Nose/Mouth/Throat: sinus pressure/pain, painful/ringing ears, toothache, difficulty swallowing, **none**
Respiratory: difficulty breathing, cough, asthma, sleep apnea, **none**
Neurological: headaches, numbness, dizziness, seizures, balance changes, **none**
Musculoskeletal: arthritis, back pain, joint pain, broken bones, **none**
Gastrointestinal: vomiting, diarrhea, irritable bowel, heartburn, **none**
Genitourinary: kidney disease, irregular menses, sexually-transmitted disease, **none**
Integumentary: rashes, eczema, dry skin, **none**
Autoimmune: rheumatoid arthritis, lupus, multiple sclerosis, **none**
Allergic: pollen, mold, dust, pets, food _____, other _____

Patient initial _____ date _____ (parent/guardian must initial if patient is under 17)
Doctor initial _____ date _____