HEALTH QUESTIONNAIRE

Kris E. Smith, O.D. Kori Watkins, O.D. Craig S. Horner, O.D.

PATIENT NAME: _____ DATE: _____

PRIMARY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

PATIENT DATE OF BIRTH: _____ SEX: M or F MARITAL STATUS: _____

PATIENT EMPLOYER: _____ EMPLOYER PHONE NUMBER: _____

PATIENT SOCIAL SECURITY NUMBER: _____ EMERGENCY CONTACT: _____

EMERGENCY CONTACT PHONE NUMBER: _____ RELATIONSHIP: _____

DO YOU WEAR GLASSES? _____ HOW OLD ARE THEY? _____

DO YOU WEAR CONTACT LENSES? _____ ARE THEY SOFT DISPOSABLE / RGP / OTHER? _____

HOW OLD ARE THEY? _____ WHAT BRAND ARE THEY? _____

DO YOU WANT TO BE FIT WITH CONTACT LENSES TODAY? _____

ARE YOU HAVING PROBLEMS WITH YOUR VISION, YOUR GLASSES OR YOUR CONTACT LENSES? PLEASE EXPLAIN:

_____

_____

MEDICAL HISTORY DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

1. PREGNANT / NURSING YES / NO	**10.** EYE INFECTIONS YES / NO	**18.** RETINAL DETACHMENT YES / NO
2. INJURIES YES / NO	**11.** PROMINENT EYES YES / NO	**19.** RETINAL DISEASE YES / NO
3. ALLERGIES YES / NO	**12.** GLAUCOMA YES / NO	**20.** STROKE YES / NO
4. SURGERIES YES / NO	**13.** EYE INJURIES YES / NO	**21.** HEART DISEASE YES / NO
5. CATARACTS / SX YES / NO	**14.** HEADACHES YES / NO	**22.** HIGH BLOOD PRESSURE YES / NO
6. LAZY EYE YES / NO	**15.** MIGRAINES YES / NO	**23.** SEE SPOTS OR FLASHES YES / NO
7. DROOPY LIDS YES / NO	**16.** LASIK SURGERY YES / NO	**24.** THYROID PROBLEM YES / NO
8. CROSSED EYES YES / NO	**17.** DOUBLE VISION YES / NO	**25.** HEART ATTACK YES / NO
9. DIABETES YES / NO ** TYPE I / TYPE II		**26.** MEDICATIONS YES / NO

IF YOU CIRCLED YES TO ANY OF THE ABOVE EXPLAIN: _____

_____

_____

_____

LIST ALL MEDICATIONS: _____

_____

SOCIAL HISTORY

DO YOU DRIVE? YES / NO DO YOU HAVE VISUAL DIFFICULTY WHILE DRIVING? _____

DO YOU USE TABACCO PRODUCTS? YES / NO DO YOU DRINK ALCOHOL? YES / NO DO YOU USE ILLEGAL DRUGS? YES / NO

HAVE YOU EVER BEEN EXPOSED TO OR INFECTED WITH: HEPATITIS or HIV? _____

DOCTOR SIGNATURE _____ DATE _____

REVIEWED PREVIOUS HISTORY (PERSONAL/FAMILY) AND TOTAL CASE RECORD. ANY CHANGES NOTED AND RECORDED IN ABOVE DATED VISIT. THIS VISIT PART OF TOTAL CASE RECORD.

OFFICE USE

Previous Eyeglass Rx: O.D. _____ ADD: _____ LENS: _____

O.S. _____ ADD: _____ BASE: _____