Shreya Patel OD PC
Patient History Questionnaire

Date_____
Last Name_____ First Name_____ MI_____ Date of Birth_____
Address_____ City _____ State _____ Zip _____
Telephone (H) _____ (W) _____ (C) _____
Email_____ Social Security #_____
Occupation_____ Employer_____
Location of Last Eye Exam?_____How long ago?_____
Whom may we thank for referring you?_____

MEDICAL AND SOCIAL INFORMATION

Do you have problems with any of these systems?

Psychiatric Y/N	Genitourinary Y/N	Blood/Lymph Y/N	Allergic/Immunologic Y/N
Endocrine Y/N	Respiratory Y/N	Ears/Nose/Throat Y/N	Neurologic Y/N
Gastrointestinal Y/N	Skin Y/N	Musculoskeletal Y/N	Cardiovascular/Blood Vessels Y/N

Please explain _____
Other health conditions:_____
Please answer all that apply
Diabetes Y/N Type_____ How many years?_____
Allergies Y/N Allergic to what?_____ Reaction?_____
Medication Allergy Y/N To what?_____ Reaction?_____
Frequent Headaches Y/N Migraines Y/N
Current Medications (include vitamins, OTC meds):_____
Are you pregnant or nursing? Y/N
Have you had any surgery? Y/N Kind?_____ When?_____
Currently use cigarettes/tobacco Y/N how much?_____ Alcohol?_____ Other Substance?_____
Do you use the computer? Y/N hours per day_____
Do you drive? Y/N
Family Doctor_____ Date of last visit_____ Reason_____

FAMILY HISTORY

High Blood Pressure: Y/N Relation_____ Macular Degeneration: Y/N Relation_____
Diabetes: Y/N Relation_____ Retinal Disease: Y/N Relation_____
Glaucoma: Y/N Relation_____ Cataracts: Y/N Relation_____
Cancer: Y/N Relation_____ Crossed Eyes: Y/N Relation_____
Other eye conditions: Y/N What kind?_____ Relation_____

PERSONAL EYE INFORMATION

Do you have any of the following: Flashes of light? Y/N Floaters? Y/N Blurred Vision? Y/N Dryness? Y/N
Burning? Y/N Itching? Y/N Excess Tearing? Y/N Sandy/Gritty feeling? Y/N
Have you had any eye surgeries or treatment for eyes? Y/N Type_____Date_____
Have you had any eye injuries? Y/N Type_____ Date_____
Have you been diagnosed with: Glaucoma? Y/N Cataracts? Y/N Macular Degeneration? Y/N Amblyopia? Y/N
Dry Eye? Y/N Lazy Eye/Eye turn? Y/N
Where you ever advised to wear an eye patch during childhood? Y/N Which eye?_____
Other eye conditions: Y/N Explain:_____
Do you wear glasses? Y/N Age of current pair:_____
Contacts? Y/N Which brand and prescription?_____