Shreya Patel OD PC
DOCTOR OF OPTOMETRY

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?____

Current Medications (including vitamins and OTC)____
____

Medication allergy Y/N which one?______________________________ reaction?____________________________________

Family Doctor____________________________ Date of last visit_________Reason____________________________________

Do you have a problem in any of the following areas?

Psychiatric Y/N
Endocrine (Diabetes, Thyroid etc) Y/N
Respiratory (ie asthma) Y/N
Skin (rosacea, warts, cancer etc)Y/N

Blood/Lymph (amenia, cholesterol etc) Y/N
Ears/Nose/Throat (sinus, dry mouth etc)Y/N
Musculoskeletal (ie Arthritis) Y/N
Gastrointestinal Y/N

Allergic/Immunologic Y/N
Neurologic (Multiple Sclerosis)Y/N
Cardiovascular (Heart attack, High Blood Pressure, Stroke)Y/N
Genitourinary Y/N

Please list/explain all major ilnesses and surgeries: ____
____
____
____

Diabetes Y/N Type__________ How many years?______________
Frequent Headaches Y/N Migraines Y/N
Are you pregnant or nursing? Y/N
Currently use cigarettes/tobacco Y/N how much?_______ Alcohol?______________ Other Substance?____________
Do you drive? Y/N
Do you use the computer? Y/N hours per day_______

PERSONAL EYE INFORMATION

Do you currently problems with 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 been diagnosed with any of the following?
Glaucoma Y/N Cataracts Y/N Macular Degeneration Y/N Amblyopia Y/N Dry Eye Y/N Lazy Eye/Eye turn 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______________
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: ____

FAMILY HISTORY (parents siblings grandparents)

Macular Degeneration: Y/N Relation_______ Retinal Disease: Y/N Relation_______ Glaucoma: Y/N Relation_______
Cataracts: Y/N Relation_____Other eye conditions: Y/N What kind?________________________________ Relation_____