Puget Sound Eye Care
Patient History & Medical Questionnaire

Name:_______________

Primary Care Physician

____

Primary Care Physician and Clinic Name

____

Address City State Zip Phone

Referring Physician

____

Referring Physician and Clinic Name

____

Address City State Zip Phone

Health History

What is the main reason for today's exam?_______________ When was your last exam?___________

When was your last health exam? ____

Past Illness or Injuries:____

Past Surgeries: ____

Current Medications: ____

____

Current Eye Drops: ____

Medicines that cause reactions or sensitivities: ____

Specific Allergies: ____

Eye History

Condition		Condition		Condition	
Amblyopia (Lazy Eye)	☐Yes ☐No	Excess Tearing/Watering	☐Yes ☐No	Loss of Side Vision	☐Yes ☐No
Blurred Vision Distance	☐Yes ☐No	Eye Pain or Soreness	☐Yes ☐No	Loss of Vision	☐Yes ☐No
Blurred Vision Near	☐Yes ☐No	Floaters or Spots	☐Yes ☐No	Macular Degeneration	☐Yes ☐No
Burning	☐Yes ☐No	Fluctuating Vision	☐Yes ☐No	Mucous Discharge	☐Yes ☐No
Cataract(s)	☐Yes ☐No	Foreign Body Sensation	☐Yes ☐No	Redness	☐Yes ☐No
Color Blindness	☐Yes ☐No	Glare/Light Sensitivity	☐Yes ☐No	Retinal Detachment	☐Yes ☐No
Distorted Vision (Halos)	☐Yes ☐No	Glaucoma	☐Yes ☐No	Sandy or Gritty Feeling	☐Yes ☐No
Double Vision	☐Yes ☐No	Headaches	☐Yes ☐No	Strabismus	
Drooping Eyelid	☐Yes ☐No	Infection of Eye or Lid	☐Yes ☐No	(Crossed Eyes)	☐Yes ☐No
Dryness	☐Yes ☐No	Itching	☐Yes ☐No	Tired Eyes	☐Yes ☐No

General Health Condition

Condition		Condition		Condition	
Fever	☐Yes ☐No	Gastrointestinal	☐Yes ☐No	Anxiety or Depression	☐Yes ☐No
Weight Loss	☐Yes ☐No	Kidney	☐Yes ☐No	Thyroid, Diabetes	☐Yes ☐No
Other symptoms	☐Yes ☐No	Muscles, Bones, Joints	☐Yes ☐No	Blood/Lymph	☐Yes ☐No
Ears, Nose, Throat	☐Yes ☐No	Skin	☐Yes ☐No	Allergic	☐Yes ☐No
Cardiovascular	☐Yes ☐No	Neurological	☐Yes ☐No	Are you?	☐Pregnant ☐Nursing
(High Blood Pressure etc)		(Multiple Sclerosis)			
Respiratory (Asthma)	☐Yes ☐No				

Family History

Condition		Condition	
Amblyopia (Lazy Eye)	☐Yes ☐No Who:_________	High Blood Pressure	☐Yes ☐No Who:_________
Arthritis	☐Yes ☐No Who:_________	Kidney Disease	☐Yes ☐No Who:_________
Blindness	☐Yes ☐No Who:_________	Lupus	☐Yes ☐No Who:_________
Cancer	☐Yes ☐No Who:_________	Macular Degeneration	☐Yes ☐No Who:_________
Cataract(s)	☐Yes ☐No Who:_________	Retinal Detachment	☐Yes ☐No Who:_________
Color Blindness	☐Yes ☐No Who:_________	Strabismus (Crossed Eyes)	☐Yes ☐No Who:_________
Diabetes	☐Yes ☐No Who:_________	Stroke	☐Yes ☐No Who:_________
Glaucoma	☐Yes ☐No Who:_________	Thyroid	☐Yes ☐No Who:_________
Heart Disease	☐Yes ☐No Who:_________	Others	☐Yes ☐No Who:_________

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Social History

Current Occupation:_____________________Employer:_____________Years:________________

Spectacle Lens History

Do you use a computer? ☐Yes ☐No How many hours/day?_________Distance from computer? ___________
Do you drive? ☐Yes ☐No Mileage to work each way? ________________
Do you have glare problems? ☐Yes ☐No
Do you have visual difficulty when driving? ☐Yes ☐No
Do you have problems with night vision? ☐Yes ☐No
Do you currently wear glasses ☐Yes ☐No Since ____________
Type of glasses: ☐Full Time ☐Part Time ☐Distance ☐Close
Glasses owned:
☐Single Vision ☐Bifocals ☐Trifocals ☐Backup ☐Safety ☐Sports ☐Progressive
Have you had trouble in the past with glasses? ☐Yes ☐No ______________________________
Do you wear sunglasses? ☐Yes ☐No Are your sunglasses your current prescription? ☐Yes ☐No

Special Eyewear Needs

☐Computer ☐Safety Glasses ☐Occupational ☐Sports/Hobbies

Contact Lens History

If not a contact lens wearer, are you interested in trying them at this time? ☐Yes ☐No
Have you ever tried to wear contact lenses? ☐Yes ☐No Reason for stopping? _______________
Do you currently wear contact lenses? ☐Yes ☐No Since ________________
Type and brand of contact lenses ____
Today's wearing time:_________ How many hours/day? ________How many days/week? ________
Pease rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	____	____	Distance Vision	____	____	Near Vision	____	____

What solutions do you use?
Cleaner _______________Disinfectant__________________Enzyme _____________________

Social History

Do you use nutritional supplements (vitamins etc)? ☐Yes ☐No
Do you engage in regular exercise? ☐Yes ☐No
Do you drink alcohol? If yes, how much/often:_____ ☐No ☐Occasional ☐1 Per Day ☐2-3/day ☐4+/day
Do you smoke? If yes, how much/often:______ ☐No ☐Occasional ☐1/2 pack/day ☐1pack/day ☐1+pack/day
Method of tobacco intake: ____
Hobbies/Interests:____

History Review: Date _______________ Date _______________ Date _______________

(For Staff Use) Clinician Initial________ Clinician Initial________ Clinician Initial________

Date _______________ Date _______________ Date _______________

Clinician Initial________ Clinician Initial________ Clinician Initial________