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| **Patient Health Questionnaire**  **Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Age**:\_\_\_\_\_\_\_\_ **Gender**: M / F **Phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Home Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_ ZIP Code:\_\_\_\_\_\_\_\_\_\_\_\_  **May we text you at this number for appointment reminders and for glasses/contact lens pickup?** Yes No |
| **Vision Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **ID**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Primary SSN:** \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_  **Medical Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **ID**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Primary Care Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Primary Care Physician Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Please circle any CURRENT eye concerns:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Itchy Eyes | Pain | Red Eye | Dry Eye | Cataracts | Retinal Detachment | Blurry Vision | | Burning Eyes | Eye Fatigue | Eye Strain | Squinting | Eye Turn | Macular Degeneration |  | | Headache | Double Vision | Floaters | Watering | Glaucoma | Flashes of light |  | |
| Do you currently wear glasses? **Yes No** Have you noticed a change in vision with your glasses/contacts? **Yes No**  Do you have glare or trouble driving at night? **Yes No** Do you work at a computer? **Yes No** How many hours/day? **\_\_\_\_\_\_**  Do you currently wear contact lenses? **Yes No** Are you interested in learning more about contact lenses today? **Yes No**  Do you play sports? **Yes No** Do you have a need for sports goggles? **Yes No** |
| Are you a smoker? **Yes No** Alcohol use? **Yes No** Narcotic use**: Yes No Female Patients**:Pregnant? **Yes No** Breastfeeding? **Yes No**  **Please circle any CURRENT or PAST problems:**   |  |  | | --- | --- | | Migraines | Weight gain/loss | | Trouble breathing | Allergies | | Asthma | COPD | | Emphysema | Diabetes | | Heart Disease | High Blood Pressure | | High Cholesterol | Stomach | | Arthritis | Muscle Pain | | Joint Pain | Anemia | | Bleeding | Thyroid | | Anxiety | Rosacea | | Depression | Rash | | Bipolar  Sjogren’s | Eczema  HIV/AIDS |  |  |  | | --- | --- | | **Please circle if anyone in your FAMILY has any of these conditions and indicate their relationship to you:** | | | Diabetes | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | Heart Disease | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | High Cholesterol | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | High Blood Pressure | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | Thyroid Disease | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | Blindness | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | Glaucoma | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | Cancer | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | Macular Degeneration | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | Retinal Detachment | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | Other | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |  |  |   **Current Medications (Please list):**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Allergies (medication/other):**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Please list any major general surgeries or hospitalizations (please include approximate dates):**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sign:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ROS:\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ ROS:\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ ROS:\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ |