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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 |
| BipolarSjogren’s | EczemaHIV/AIDS |

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| --- |
| **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: \_\_\_\_\_\_\_\_\_ |