Patient Label

New Adult Ophthalmology Patient Questionnaire

If you are not adult, please request a pediatric patient questionnaire

Who is your primary care doctor? ____

Which doctor referred you to our practice____

What problem are you having with your eyes? ☐Misaligned eyes ☐Double Vision ☐Other:________________

Your Past Medical History (Check all that apply)

☐Arthritis
☐Asthma
☐Allergies
☐Bleeding problems
☐Cancer
List_________________
☐Diabetes
Type________________
☐Heart disease
List_________________

☐Gastrointestinal problems
List_________________
☐Kidney problems
☐Lung problems
List_________________
☐Seizure disorder
☐Skin problems
List_________________
☐Stroke

☐Thyroid problems
List_________________
☐Urinary problems
List_________________
☐________________
☐________________
☐________________
☐________________

Your Past Eye History (Check all that apply)

☐Amblyopia(Lazy eye) R L
☐Cataracts R L
☐Misaligned eyes
☐Diabetic eye disease
☐Droopy eye lid R L

☐Glaucoma R L
☐Glasses
☐Injury to eye R L
☐Retinal detachment R L
☐________________

☐________________
☐________________
☐________________
☐________________

Hospitalizations:

____
____
____
____
____

Surgeries:

____
____
____
____
____

Family History (Check all that apply and list relationship)

☐Asthma
☐Bleeding problems
☐Cancer
List_________________
☐Cholesterol problems
☐Diabetes
☐Heart disease

☐High blood pressure
☐Liver disease
☐Lung disease
☐Mental illness
List_________________
☐Muscle disorders
☐Sickle cell disease

☐Stroke
☐Thyroid problems
☐________________
☐________________
☐________________
☐________________

Social History:

What kind of work do you do? ______________________________ Marital status: _______________________

Are there any special social issues we should know about? ____

List Your Medication Allergies:

____

List medications you are taking (Use back if need or provide your personal list for us to review):

Name of Medicine	Dose	Frequency taken
____________	________	______________
____________	________	______________
____________	________	______________
____________	________	______________
____________	________	______________
____________	________	______________

Review of Systems: Are you experiencing problems with any of the following right now?

Explanation of Symptoms

EARS, NOSE AND THROAT ( ) Y ( ) N
Hearing loss, ear infections, chronic cough, etc. ______________________________
CARDIOVASCULAR ( ) Y ( ) N
Heart or blood vessel problems ______________________________
RESPIRATORY ( ) Y ( ) N
Asthma, breathing difficulties, etc. ______________________________
GASTROINTESTINAL ( ) Y ( ) N
Intestinal or digestive problems ______________________________
UROLOGIC/GENITAL ( ) Y ( ) N
Urinary infections, kidney disease ______________________________

MUSCLES, BONES, JOINTS ( ) Y ( ) N
Arthritis,
orthopedic problems, etc. ______________________________
SKIN ( ) Y ( ) N
Acne, warts, molluscum, etc. ______________________________
NEUROLOGICAL ( ) Y ( ) N
Headaches, hydrocephalus, etc. ______________________________
PSYCHIATRIC ( ) Y ( ) N
Anxiety, depression, etc. ______________________________

ENDOCRINE ( ) Y ( ) N
Complications of Diabetes, thyroid disease, etc. ______________________________
BLOOD, LYMPHATIC ( ) Y ( ) N
Anemia, cholesterolemia, etc. ______________________________
ALLERGIC/IMMUNOLOGIC ( ) Y ( ) N
Hay fever, allergies, lupus, etc. ______________________________
COMMENTS____
____

______________________________ ____________________
Patient Signature Date