HEALTH QUESTIONNAIRE

Kris E. Smith, O.D. Gabrielle A. Hinton, O.D. Craig S. Horner, O.D.

PATIENT NAME: _____ DATE: _____

PRIMARY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

PATIENT DATE OF BIRTH: _____ SEX: M or F MARITAL STATUS: _____

PATIENT EMPLOYER: _____ EMPLOYER PHONE NUMBER: _____

PATIENT SOCIAL SECURITY NUMBER: _____ EMERGENCY CONTACT: _____

EMERGENCY CONTACT PHONE NUMBER: _____ RELATIONSHIP: _____

DO YOU WEAR GLASSES? _____ HOW OLD ARE THEY? _____

DO YOU WEAR CONTACT LENSES? _____ ARE THEY SOFT DISPOSABLE / RGP / OTHER? _____

HOW OLD ARE THEY? _____ WHAT BRAND ARE THEY? _____

DO YOU WANT TO BE FIT WITH CONTACT LENSES TODAY? _____

ARE YOU HAVING PROBLEMS WITH YOUR VISION, YOUR GLASSES OR YOUR CONTACT LENSES? PLEASE EXPLAIN:

_____

_____

MEDICAL HISTORY DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

1.	PREGNANT / NURSING	YES / NO	**10.**	EYE INFECTIONS	YES / NO	**18.**	RETINAL DETACHMENT	YES / NO
2.	INJURIES	YES / NO	**11.**	PROMINENT EYES	YES / NO	**19.**	RETINAL DISEASE	YES / NO
3.	ALLERGIES	YES / NO	**12.**	GLAUCOMA	YES / NO	**20.**	STROKE	YES / NO
4.	SURGERIES	YES / NO	**13.**	EYE INJURIES	YES / NO	**21.**	HEART DISEASE	YES / NO
5.	CATARACTS / SX	YES / NO	**14.**	HEADACHES	YES / NO	**22.**	HIGH BLOOD PRESSURE	YES / NO
6.	LAZY EYE	YES / NO	**15.**	MIGRAINES	YES / NO	**23.**	SEE SPOTS OR FLASHES	YES / NO
7.	DROOPY LIDS	YES / NO	**16.**	LASIK SURGERY	YES / NO	**24.**	THYROID PROBLEM	YES / NO
8.	CROSSED EYES	YES / NO	**17.**	DOUBLE VISION	YES / NO	**25.**	HEART ATTACK	YES / NO
9.	DIABETES	YES / NO ** TYPE I / TYPE II				**26.**	MEDICATIONS	YES / NO

IF YOU CIRCLED YES TO ANY OF THE ABOVE EXPLAIN: _____

_____

_____

_____

LIST ALL MEDICATIONS: _____

_____

SOCIAL HISTORY

DO YOU DRIVE? YES / NO DO YOU HAVE VISUAL DIFFICULTY WHILE DRIVING? _____

DO YOU USE TABACCO PRODUCTS? YES / NO DO YOU DRINK ALCOHOL? YES / NO DO YOU USE ILLEGAL DRUGS? YES / NO

HAVE YOU EVER BEEN EXPOSED TO OR INFECTED WITH: HEPATITIS or HIV? _____

DOCTOR SIGNATURE _____ DATE _____

REVIEWED PREVIOUS HISTORY (PERSONAL/FAMILY) AND TOTAL CASE RECORD. ANY CHANGES NOTED AND RECORDED IN ABOVE DATED VISIT. THIS VISIT PART OF TOTAL CASE RECORD.

OFFICE USE

Previous Eyeglass Rx: O.D. _____ ADD: _____ LENS: _____

O.S. _____ ADD: _____ BASE: _____