WELCOME to Select Eyecare - Loganville
Patient History Questionnaire

First Name* | Last Name* | Initial

Nickname | Date of Birth* (mm/dd/yyyy) | Gender: Male Female

Home Phone | Work Phone | Cell Phone*

SSN* | Parent / Guardian

Address* | Address Line 2

City* | State* (Select a State/Province) | Zip*

Email* | Occupation | Computer Usage

Special Needs | Hobbies / Sports

Family Doctor | Dr Phone

Alternative Contact | Relationship to Patient

Primary Phone | Alternate Phone

Note: For Dates where exact date is unknown, please use a number that is as close as you can remember.

Last Eye Exam (mm/dd/yyyy) | Last Medical Exam (mm/dd/yyyy)

Review of Systems

Do you currently or have you ever had any problems in the following areas:

Constitutional

Fever	Yes	No	?
Weight Gain / Loss	Yes	No	?

Integumentary

Skin	Yes	No	?

Neurological

Headaches	Yes	No	?
Migraines	Yes	No	?
Seizures	Yes	No	?

Eyes

Loss of Vision	Yes	No	?
Blurred Vision	Yes	No	?
Distorted Vision / Halos	Yes	No	?
Loss of Side Vision	Yes	No	?
Double Vision	Yes	No	?
Dryness	Yes	No	?
Mucous Discharge	Yes	No	?
Redness	Yes	No	?
Itching	Yes	No	?
Burning	Yes	No	?
Foreign Body Sensation	Yes	No	?
Excess Tearing	Yes	No	?
Glare / Light Sensitivity	Yes	No	?
Eye Pain / Soreness	Yes	No	?
Chronic Infection of Eye or Lid	Yes	No	?
Styes or Chalazion	Yes	No	?
Flashes	Yes	No	?
Floaters in Vision	Yes	No	?
Tired Eyes	Yes	No	?

Ear, Nose, Throat and Mouth

Allergies / Hey Fever	Yes	No	?
Sinus Congestion	Yes	No	?
Runny Nose	Yes	No	?
Post-Nasal Drip	Yes	No	?
Chronic Cough	Yes	No	?
Dry Throat / Mouth	Yes	No	?
Ringing in Ears	Yes	No	?
Ear Pain / Infection	Yes	No	?
Hearing Aids	Yes	No	?
Deaf	Yes	No	?

Vascular, Cardiovascular

Diabetes	Yes	No	?
Heart Disease	Yes	No	?
High Blood Pressure	Yes	No	?
High Cholesterol	Yes	No	?

Gastrointestinal

Diarrhea	Yes	No	?
Constipation	Yes	No	?

Genitourinary

Gonads / Kidneys / Bladder	Yes	No	?

Bones, Joints and Muscles

Rheumatoid Arthritis	Yes	No	?
Muscle Pain	Yes	No	?
Joint Pain	Yes	No	?

Lymphatic, Hematological

Anemia	Yes	No	?
Bleeding Problems	Yes	No	?

Endocrine

Thyroid Glands	Yes	No	?
Other Glands	Yes	No	?

Respiratory

Asthma ○ Yes ○ No ○ ?
Emphysema ○ Yes ○ No ○ ?

Allergic, Immunologic ○ Yes ○ No ○ ?
Psychiatric ○ Yes ○ No ○ ?

Chronic Bronchitis ○ Yes ○ No ○ ?
Sleep Apnea ○ Yes ○ No ○ ?

If you answered yes to any of the above or have a condition not listed, please explain and list medications if any.

Family History

Please note any family history (parents, grandparents, siblings, living or deceased) for the following conditions

Blindness	○ Yes	○ No	○ ?	Relationship	
Cataract	○ Yes	○ No	○ ?	Relationship	
Glaucoma	○ Yes	○ No	○ ?	Relationship	
Crossed Eyes	○ Yes	○ No	○ ?	Relationship	
Macular Degeneration	○ Yes	○ No	○ ?	Relationship	
Retinal Detachment	○ Yes	○ No	○ ?	Relationship	
Arthritis	○ Yes	○ No	○ ?	Relationship	
Cancer	○ Yes	○ No	○ ?	Relationship	
Diabetes	○ Yes	○ No	○ ?	Relationship	
Heart Disease	○ Yes	○ No	○ ?	Relationship	
High Blood Pressure	○ Yes	○ No	○ ?	Relationship	
High Cholesterol	○ Yes	○ No	○ ?	Relationship	
Kidney Disease	○ Yes	○ No	○ ?	Relationship	
Lupus	○ Yes	○ No	○ ?	Relationship	
Thyroid Disease	○ Yes	○ No	○ ?	Relationship	
Other	○ Yes	○ No	○ ?	Relationship	

If other, please explain

Medical History

Do you have any allergies to medications?
○ Yes ○ No
If yes, please explain

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies)

List all major injuries, surgeries and / or hospitalizations you have had

List any of the following that you have had

Prominent Eyes ○ Yes ○ No
Eye Infection ○ Yes ○ No
Cataracts ○ Yes ○ No
Are you pregnant? ○ Yes ○ No
Do you wear glasses? ○ Yes ○ No

Crossed Eyes ○ Yes ○ No
Retinal Disease ○ Yes ○ No
Eye Injury ○ Yes ○ No

Lazy Eye ○ Yes ○ No
Glaucoma ○ Yes ○ No
Drooping Eyes ○ Yes ○ No

If yes, how old are your present glasses? (Years)

Do you wear contacts?
Yes No

If yes, how old are your present pair of lenses? (Weeks)

Type of contact lenses
Rigid Soft Extended Wear Other

Are they comfortable?
Yes No

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

I would prefer to discuss my social history information directly with my doctor

Do you drive?
Yes No

If yes, do you have visual difficulty when driving?
Yes No

If yes, please describe

Do you use tobacco products?
Yes No

If yes, type / amount / how long?

Do you use alcohol?
Yes No

If yes, type / amount / how long?

Do you use illegal drugs?
Yes No

If yes, type / amount / how long?

Have you ever been exposed to or infected with:

Gonnorhea Yes No
Syphilis Yes No
Hepatitis Yes No
HIV / AIDS Yes No

Whom may we thank for referring you?

Doctor

Patient

Friend

TV Commercial Newspaper Magazine Ad Yellow Pages Radio Ad Seminar Our Web Site Internet Search

Other