Patient History Questionnaire

Cool Optometry

Eye Examination Date:

_____/_____/_____

Full Name: _____ Birth Date: _____/_____/_____

Address: _____ Social Security Number: _____

_____ Home Phone: _____

Email: _____ Cell Phone: _____

Occupation: _____ Last Medical Exam: _____/_____/_____

Employer: _____ Medical Doctor: _____

Previous Eye Doctor: _____ Medical Insurance: _____

Responsible Party if different: _____ Relationship to Patient: _____

Emergency Contact/Phone: _____

VISION INSURANCE: ___VSP ___MES ___Superior ___EyeMed ___Davis Other_____

Are you the primary member: ☐ No ☐ Yes

If Not Subscribers name: _____DOB_____/_____/_____ Social Security Number:_____

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ No ☐ Yes If yes, what brand? _____

What other services would you like to be evaluated for?

- ☐ Contact lenses
- ☐ Non-prescription sunglasses
- ☐ Prescription sunglasses
- ☐ Progressive lenses
- ☐ Computer glasses
- ☐ Reading glasses

How did you find out about us?:

- ☐ Facebook
- ☐ Location
- ☐ Yelp
- ☐ Google
- ☐ Other: _____
- ☐ Word of mouth
- ☐ Community Event

Who referred you, if anyone?: _____

Have you had eye surgery? Ex: Lasik, cataracts, etc. ____ If yes, Date _____ Type _____

Are you currently experiencing any of the following problems with your eyes? **Check box if "YES."**

- ☐ Blurred vision
- ☐ Loss of vision
- ☐ Loss of side vision
- ☐ Distorted vision
- ☐ Double vision
- ☐ Tired eyes

- □ Flashes
- □ Floaters in vision
- □ Dryness
- □ Sandy or gritty feeling
- □ Burning
- □ Itching
- □ Redness
- □ Excess Tearing / Watering
- □ Eye pain or soreness
- □ Mucus discharge
- □ Inflamed eyelid
- □ Sties or Chalazion
- □ Halos
- □ Light sensitivity

Have you been diagnosed with any of the following ocular problems? **Check box if "YES."**

- □ Cataracts
- □ Glaucoma
- □ Lazy Eye / Amblyopia
- □ Macular Degeneration
- □ Retinal Detachment
- □ Dry Eye
- □ Eye Injury
- □ Other _____

MEDICAL HISTORY

List any medications you are currently taking (include oral contraceptives, aspirin, over the counter medications, vitamins): _____

_____

Are you allergic to any medications? Yes No If yes, which ones: _____

List all major surgeries and/or hospitalizations you have had: _____

_____

REVIEW OF SYSTEMS Please list any problem you currently have, or have had, in the following area

CARDIOVASCULAR / CARDIAC
Examples: Heart disease, high blood pressure, etc.

_____

GENITOURINARY
Examples: Kidney disease, Ovarian / Uterine cancer

_____

MUSULOSKELETAL
Examples: Rheumatoid Arthritis, joint pain, etc.

_____

PSCHIATRIC
Examples: Anxiety, depression, etc.

_____

NEUROLOGICAL
Examples: Migraines, seizures, stroke, etc.

_____

RESPIRATORY
Examples: Asthma, Bronchitis, Emphysema, etc.

_____

ENDOCRINE
Examples: Diabetes, Thyroid Disease, etc.

_____

HEMATOLOGIC / LYMPHATIC
Examples: Anemia, Breast Cancer, etc.

_____

INTEGUMENTARY (Skin)
Examples: Cancer, rashes, etc.

_____

GASTROINTESTINAL
Examples: IBS, ulcers, reflux / Gerd, etc.

_____

EARS, NOSE, MOUTH, THROAT
Examples: Sinus Congestion, Dry Throat / Mouth

_____

ALLERGIC / IMMUNOLOGIC
List any allergies: _____

Are you pregnant and/or nursing? No ☐ Yes ☐

FAMILY HISTORY Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

RELATION TO YOU

- □ Glaucoma _____
- □ Blindness _____
- □ Diabetes _____

RELATION TO YOU

- □ Macular Degeneration _____
- □ Retinal Detachment _____

Signature: _____ Date: _____/_____/_____