TX VC TEXAS VISION CLINIC

Patient History Questionnaire

Date: _____/_____/_____

Full Name: _____ Gender: M / F
(First) (Last)

Address: _____ Date of Birth: _____/_____/_____

_____ Social Security #: _____
(City) (State) (Zip)

Email Address: _____ Cell Phone: _____

Occupation: _____ Home Phone: _____

Medical Doctor: _____ Last Medical Exam: _____/_____/_____

Primary Insurance:_____ Group #:_____ ID #: _____

Policy Holder (PH): _____ Date of Birth (PH): _____ Soc. Sec. # (PH):_____

Secondary Insurance: _____ Group #:_____ ID #: _____

Policy Holder (PH): _____ Date of Birth (PH): _____ Soc. Sec. # (PH):_____

Who is responsible for payment?_____ Relationship to Patient:_____

Address: _____
(City) (State) (Zip)

★ PAYMENT IS DUE WHEN SERVICES ARE RENDERED ★

OCULAR HISTORY

Last Eye Exam: _____/_____/_____

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 type? ☐ Rigid ☐ Soft ☐ Toric ☐ Multifocal ☐ Monovision

What brand and power? _____ How frequently do you replace them?_____

Have you had refractive surgery? _____ If yes, Date _____ Type _____

What other services would you like to be evaluated for? ☐ Refractive Surgery ☐ Contact Lenses
☐ Computer Glasses ☐ Reading Glasses ☐ Sunglasses ☐ Driving Glasses

Are you having any visual difficulties? _____ If yes, please explain: _____

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

☐ Blurred Vision	☐ Flashes / Floaters in Vision	☐ Redness
☐ Loss of Vision	☐ Halos / Glare / Light Sensiitivity	☐ Excess Tearing / Watering
☐ Loss of Side Vision	☐ Dryness	☐ Eye Pain or Soreness
☐ Distorted Vision	☐ Sandy or Gritty Feeling	☐ Mucous Discharge
☐ Double Vision	☐ Burning	☐ Inflammation of the Eyelid
☐ Tired Eyes	☐ Itching	☐ Styes or Chalazion

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

☐ Cataracts	☐ Glaucoma	☐ Retinal Detachment / Disease
☐ Crossed Eyes	☐ Lazy Eye / Amblyopia	☐ Dry Eye
☐ Eye Injury	☐ Macular Degeneration	☐ Other _____

MEDICAL HISTORY

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

_____

_____

_____

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

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

_____

REVIEW OF SYSTEMS

Please check the box beside any problem you currently have, or have had, in the following areas:

CONSTITUTIONAL ☐ All Normal
- ☐ Fever
- ☐ Weight Loss / Gain

EARS, NOSE, MOUTH, THROAT ☐ All Normal
- ☐ Sinus Congestion
- ☐ Dry Throat / Mouth

NEUROLOGICAL ☐ All Normal
- ☐ Migraines
- ☐ Dizziness
- ☐ Seizures
- ☐ Stroke

PSYCHIATRIC ☐ All Normal
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss
- ☐ Hallucinations

CARDIOVASCULAR / CARDIAC ☐ All Normal
- ☐ Arteriosclerosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol

RESPIRATORY ☐ All Normal
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Cough

GASTROINTESTINAL ☐ All Normal
- ☐ Diarrhea / Constipation
- ☐ IBS / Crohn's Disease
- ☐ Reflux

GENITOURINARY ☐ All Normal
- ☐ Kidney Disease
- ☐ Ovarian / Uterine Cancer
- ☐ Prostate Cancer

MUSCULOSKELETAL ☐ All Normal
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint Pain

INTEGUMENTARY (Skin) ☐ All Normal
- ☐ Cancer
- ☐ Rashes
- ☐ Easy Bruising

ENDOCRINE ☐ All Normal
- ☐ Diabetes Type I / II x____ years
- ☐ Thyroid Disease
- ☐ Chronic Fatigue

HEMATOLOGIC / LYMPHATIC ☐ All Normal
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Breast Cancer

ALLERGIC / IMMUNOLOGIC ☐ All Normal
- ☐ Allergy / Hay Fever

If you checked any of the above boxes or have a condition not listed, please explain further: _____

_____

Do You Consume alcohol? ☐ No ☐ Yes
☐ If yes, Average drinks/week: _____

Do You Smoke ☐ No ☐ Yes
If yes, number of packs/day:_____ How many years?_____

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

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children) for the following conditions:

	RELATION TO YOU		RELATION TO YOU
☐ Glaucoma	_____	☐ Diabetes	_____
☐ Cataract	_____	☐ Cancer	_____
☐ Macular Degeneration	_____	☐ Heart Disease	_____
☐ Retinal Detachment	_____	☐ High Blood Pressure	_____
☐ Blindness	_____	☐ Kidney Disease	_____
☐ Crossed Eyes	_____	☐ Lupus / Arthritis	_____

Signature: _____ Date _____/_____/_____