Patient Information

Patient Name _____ _____ _____
First Name Middle Initial Last Name

Date of Birth _____ **Email Address:** _____
☐ I do not have an email account

Gender: ☐ Male ☐ Female ☐ Other

Race: ☐ American Indian or Alaska Native ☐ Asian
☐ Native Hawaiian or Other Pacific Islander ☐ White
☐ Black or African American ☐ Other Race

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Who shall we contact in case of an emergency?

First Name _____ **Last Name** _____

Home Phone (_____) _____ **Relationship:** ☐ Single ☐ Married ☐ Widowed ☐ Separated

Work Phone (_____) _____ **Cell Phone** (_____) _____

Eye Surgeries

- IF YOU HAVE EVER HAD AN OPERATION ON YOUR EYES, PLEASE FILL OUT ALL OF THE REQUESTED INFORMATION.
- IF YOU HAVE HAD NO EYE SURGERIES, SELECT "NONE" IN THE 'NAME OF PROCEDURE BOX."

Date of Surgery _____ **Surgeon** _____

Name of Procedure:

☐ Cataract surgery
☐ Comeal Foreign Body
☐ Corneal Transplant
☐ Eye Muscle or Strabismus Surgery
☐ Eyelash Removal
☐ Retinal Detachment
☐ Eyelid Surgery
☐ Glaucoma Surgery
☐ Laser treatment of retina
☐ LASIK
☐ None
☐ Punctal Plugs
☐ RK

Ocular History

DIAGNOSIS OF GLAUCOMA? ☐ Yes ☐ No

DIAGNOSIS OF CATARACTS? ☐ Yes ☐ No

If yes, Check one:

- ☐ Cataract removed right eye
- ☐ Cataract removed left eye
- ☐ Cataract removed both eyes
- ☐ Beginning cataract

HAVE YOU EVER HAD AN EYE INJURY? ☐ Yes ☐ No

If yes, Check all that apply:

- ☐ Corneal Abrasion Right eye
- ☐ Corneal Abrasion Left eye
- ☐ Penetrating Injury Right eye
- ☐ Penetrating Injury Left eye
- ☐ Eye lid injury Right
- ☐ Eye lid injury Left

DIAGNOSIS OF RETINAL DISEASE? ☐ Yes ☐ No

If yes, Check all that apply:

- ☐ Diabetic Retinopathy
- ☐ Macular Degenration
- ☐ Macular Hole
- ☐ Retinal Detatchment
- ☐ Retinal Tear

OTHER EYE DISEASES? CHECK ALL THAT APPLY:

- ☐ Enucleation Left Eye
- ☐ Enucleation Right Eye
- ☐ Exophthalmos Both Eyes
- ☐ Exophthalmos Left Eye
- ☐ Exophthalmos Right Eye

DIAGNOSIS OF BLINDNESS / VISION LOSS? ☐ Yes ☐ No

If yes, Check all that apply:

- ☐ Congenital
- ☐ Corneal Scar
- ☐ Enucleation
- ☐ Injury Related
- ☐ Legally Blind

DIAGNOSIS OF STRABISMUS? ☐ Yes ☐ No

If yes, Check all that apply:

- ☐ Esophoria
- ☐ Esotropia
- ☐ Exophoria
- ☐ Muscle Surgery
- ☐ Exotropia
- ☐ Vertical Heterophoria
- ☐ Vertical Heterotropia

DIAGNOSIS OF AMBLYOPIA? ☐ Yes ☐ No

If yes, Check all that apply:

- ☐ Both Eyes
- ☐ One Eye
- ☐ Treatment Management: Eye Muscle Surgery
- ☐ Treatment Management: Glasses
- ☐ Treatment Management: Patching
- ☐ Treatment Management: Pharmaceutical
- ☐ Treatment Management: Vision Therapy

DO YOU HAVE OCULAR COMPLICATIONS RELATED TO DIABETES? ☐ Yes ☐ No

DIAGNOSIS OF DRY EYE? ☐ Yes ☐ No

If yes, Check your level of severity:

- ☐ Mild
- ☐ Moderate
- ☐ Severe

OTHER VISION SYMPTOMS

Eye itchiness	☐ Yes	☐ No	Flashes of light	☐ Yes	☐ No
Spuls / Floalers	☐ Yes	☐ No	Sudden loss of vision	☐ Yes	☐ No
Eye Dryness	☐ Yes	☐ No	Increased tearing	☐ Yes	☐ No
Gritty feeling in eyes	☐ Yes	☐ No	Redness	☐ Yes	☐ No
Watery eye	☐ Yes	☐ No	Trouble seeing at night	☐ Yes	☐ No
Burning eyes	☐ Yes	☐ No	Trouble working up close	☐ Yes	☐ No
Eye strain	☐ Yes	☐ No	Trouble being fit with, or adjusting to a prior pair of glasses	☐ Yes	☐ No
Sore eyes	☐ Yes	☐ No			

READING

Trouble learning at school, work or other activity	☐ Yes	☐ No
Trouble concentrating	☐ Yes	☐ No

General History

Last Eye Exam _____ (MM/DD/YYYY) **Dr Last Eye Exam** _____

DO YOU WEAR GLASSES?

☐ Yes ☐ No

If yes, please answer the below questions:

Age when glasses were first worn (in years): _____

Worn full or part time? (choose one):

Full Time	☐ Yes	☐ No
Part Time	☐ Yes	☐ No

Worn for far, near or both? (choose one):

Far Vision Only	☐ Yes	☐ No
Near Vision Only	☐ Yes	☐ No
Both Far and Near	☐ Yes	☐ No

DO YOU WEAR CONTACT LENSES?

☐ Yes ☐ No

If yes, please answer the below questions:

Age when contacts first worn (in years): _____

Worn full time or part time? (choose one):

Full Time	☐ Yes	☐ No
Part Time	☐ Yes	☐ No

DO YOU WORK AT A DESK OR ON A COMPUTER?

☐ Yes ☐ No

If yes, please answer the below questions:

Approximate distance from your eyes to the desk / computer screen (in inches): _____

How many hours per day? _____

Are glasses worn? ☐ Yes ☐ No

DO YOU PERFORM DISTANCE VIEWING (10 FEET AND BEYOND - CLASSROOM, WORK, DRIVING)?

☐ Yes ☐ No

If yes, please answer the below questions:

How many hours per day? _____

Are glasses worn? ☐ Yes ☐ No

1. OF ALL OF YOUR SYMPTOMS, CHECK THE SYMPTOM THAT IS THE WORST AND CAUSES YOU THE MOST PROBLEMS:

- ☐ Dizziness
- ☐ Headache
- ☐ Anxiety
- ☐ Neck Pain / Ache
- ☐ Reading

2. HOW LONG HAVE YOU HAD THIS WORSTSYMPTOM? (IN YEARS) _____

3. HOW SEVERE IS YOUR WORST SYMPTOM, ON AN AVERAGE DAY, ON A 0-10 SCALE (WHERE 0 IS NO SYMPTOM AND 10 IS THE WORST IT COULD BE)?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

4. OF ALL OF YOUR SYMPTOMS, CHECK THE SYMPTOM THAT IS THE SECOND WORST:

- ☐ Dizziness
- ☐ Headache
- ☐ Anxiety
- ☐ Neck Pain / Ache
- ☐ Reading

5. HOW LONG HAVE YOU HAD THIS SECOND WORST SYMPTOM (IN YEARS) _____

6. HOW SEVERE IS YOUR SECOND WORST SYMPTOM, ON AN AVERAGE DAY, ON A 0-10 SCALE (WHERE 0 IS NO SYMPTOM AND 10 IS THE WORST IT COULD BE)?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

7. PLEASE ANSWER WHETHER YOU HAVE HAD ANY OF THESE TESTS PERFORMED:

Head CT	☐ Yes	☐ No	Electronystagmogram (ENG)	☐ Yes	☐ No
MRI/MRA	☐ Yes	☐ No	Other	☐ Yes	☐ No
Audiogram	☐ Yes	☐ No			

If Other list here: _____

8. PLEASE ANSWER WHETHER YOU HAVE SEEN ANY DOCTORS / SPECIALISTS / OTHER PROVIDERS FOR THESE SYMPTOMS?

Internist	☐ Yes	☐ No	Reading Specialist	☐ Yes	☐ No
ENT (Ears / Nose /Throat)	☐ Yes	☐ No	Psychiatrist / Psychologist	☐ Yes	☐ No
Chiropractor	☐ Yes	☐ No	Pediatrician	☐ Yes	☐ No
Family Practice	☐ Yes	☐ No	Ophthalmologist	☐ Yes	☐ No
Neurologist	☐ Yes	☐ No	Optometrist	☐ Yes	☐ No
PM&R (Physical Medicine and Rehab.)	☐ Yes	☐ No	Emergency Physician / ER	☐ Yes	☐ No

If Other list here: _____

Other Questions

HAVE YOU BEEN DIAGNOSED WITH A TRAUMATIC BRAIN INJURY (TBI)? ☐ Yes ☐ No

If yes, please answer the below questions:

Who diagnosed you as having a TBI? _____

When did the TBI occur? Date: _____

Are you coming to Vision Specialists to be evaluated for symptoms that seem to have been caused by or seem to be related to TBI?

☐ Yes ☐ No

If headaches are a problem for you, please list your 3 worst headache triggers:

1. _____ 2. _____ 3. _____

If dizziness is a problem for you, please list your 3 worst dizziness triggers:

1. _____ 2. _____ 3. _____

Are you currently driving a car during the day? ☐ Yes ☐ No

Are you currently driving a car at night? ☐ Yes ☐ No

Health History

ENDOCRINE

Thyroid Disorder	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Adrenal Disorder	☐ Yes	☐ No
Female hormone replacement therapy	☐ Yes	☐ No
Male hormone replacement therapy	☐ Yes	☐ No

Other: _____

HEMATOLOGIC / LYMPHATIC

Anemia	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No
Lymphoma	☐ Yes	☐ No
Other Blood Disorders	☐ Yes	☐ No

Other: _____

CARDIOVASCULAR / HEART

Arrythmia / Irregular heart beat / palpitation	☐ Yes	☐ No
Dysautonomia / POTS	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Syncope / Fainting	☐ Yes	☐ No
Valve Replacement	☐ Yes	☐ No

Other: _____

NEUROLOGICAL

Cranial Nerve Palsy	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Epilepsy / Seizures	☐ Yes	☐ No
Feeling Uncoordinated	☐ Yes	☐ No
Migraines	☐ Yes	☐ No
Severe Headaches that aren't Migraines	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No

Other: _____

DOUBLE VISION ☐ Yes ☐ No

If yes, please answer the below questions:

1. Only at Near	☐ Yes	☐ No
Only at Far	☐ Yes	☐ No
Both	☐ Yes	☐ No

2. Vertical	☐ Yes	☐ No
Horizontal	☐ Yes	☐ No
Diagonal	☐ Yes	☐ No

EARS, NOSE AND THROAT

Benign Positional Vertigo / BPV / BPPV	☐ Yes	☐ No
Fullness Left ear	☐ Yes	☐ No
Fullness Right ear	☐ Yes	☐ No
Meniere's Disease	☐ Yes	☐ No
Ringing / Tinnitus in Left ear	☐ Yes	☐ No
Ringing / Tinnitus in Right ear	☐ Yes	☐ No
Sensation of fluid leaking from Left ear	☐ Yes	☐ No
Sensation of fluid leaking from Right ear	☐ Yes	☐ No
Sinus Disorders	☐ Yes	☐ No
Sinus Pain / Pressure	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
TMJ problem	☐ Yes	☐ No

Other: _____

RESPIRATORY / LUNGS:

Asthma	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Sarcoid	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No

Other: _____

STOMACH / INTESTINES:

Crohn's Disease	☐ Yes	☐ No
Irritable Bowel Syndrome	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Ulcerative Colitis	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No

Other: _____

INTEGUMENT / SKIN

Skin Rash	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Excessive Sweating	☐ Yes	☐ No

Other: _____

BONES / JOINTS / MUSCLES

Rheumatoid Arthritis	☐ Yes	☐ No
Polymyalgia	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No
Cerebral Palsy	☐ Yes	☐ No
Neck Pain	☐ Yes	☐ No
C-spine Fracture	☐ Yes	☐ No
C-spine Fusion	☐ Yes	☐ No

Other: _____

ALLERGIC / IMMUNOLOGIC

Seasonal Allergies	☐ Yes	☐ No
HIV	☐ Yes	☐ No
Anaphylactic Reactions	☐ Yes	☐ No

Other: _____

PSYCHIATRIC

Depression	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Panic episodes	☐ Yes	☐ No	Agoraphobia	☐ Yes	☐ No
PTSD (Post Traumatic Stress Disorder)	☐ Yes	☐ No	ADD / ADHD (Attention Deficit Disorder/ Attention Deficit Hyperactivity Disorder)	☐ Yes	☐ No

Other: _____

GENITALS / KIDNEY / BLADDER

Frequent Urination	☐ Yes	☐ No	Kidney Transplant	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No			

Other: _____

CONSTITUTION

Fatigue	☐ Yes	☐ No	Chills	☐ Yes	☐ No
Fever	☐ Yes	☐ No	Insomnia	☐ Yes	☐ No

Other: _____

History of Cancer ☐ Yes ☐ No

If YES, list what kind(s): _____

Social History

Are you or have you been a smoker? ☐ Yes ☐ No

Check one:

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker

Do you drink alcohol? ☐ Yes ☐ No

Check one:

- ☐ Social drinker
- ☐ Light drinker - 1-2u/day
- ☐ Moderate drinker - 3-6u/day
- ☐ Heavy drinker - 7-9u/day

Do you misuse/abuse drugs or medications? ☐ Yes ☐ No

Check all that apply:

- ☐ Recreational drug user
- ☐ Cannabis
- ☐ Cocaine
- ☐ Crack
- ☐ Heroin
- ☐ LSD
- ☐ Methamphetamine
- ☐ Oxycontin
- ☐ Speed

Other: _____

Occupation or Grade in school _____

Hobbies _____

Family History

DO ANY OF YOUR FAMILY MEMBERS HAVE ANY OF THE CONDITIONS LISTED BELOW?
IF YES, CHECK ALL THAT APPLY:

	Sister	Mother	Father	Brother	Paternal Grandmother	Martial Grandmother	Paternal Grandmother	Maternal Grandmother
Family History of Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐	☐
Eye Injury	☐	☐	☐	☐	☐	☐	☐	☐
Retina Disease	☐	☐	☐	☐	☐	☐	☐	☐
Other Eye Disease	☐	☐	☐	☐	☐	☐	☐	☐
Strabismus	☐	☐	☐	☐	☐	☐	☐	☐
Amblyopia	☐	☐	☐	☐	☐	☐	☐	☐
Blindness/ Vision Loss	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐

OTHER FAMILY HISTORY _____

_____

Questionnaire

Choose the appropriate age

☐ I am 13 years old or younger

☐ I am 14 years old or older