Pacific EyeClinic

Thank you for completing the questionaire below. The federal government requires us to complete the following information for compliance with new health record laws.
WE DO NOT SHARE YOUR INFORMATION

Name _____ **Date of Appointment** _____

Ethnicity: O Hispanic or Latino O Not Hispanic or Latino

Race:

O American Indian or Alaska Native	O White
O Asian	O Native American
O Black or African American	O Caucasian
O Native Hawaiian or other Pacific Islander	O Refuse to Specify
Other Race	

Primary Care Physician: _____

Preferred Pharmacy: _____

Reason for today's visit: _____

_____

Past Surgeries

Date	**Surgery**

Major Illnesses

Eg. Diabetes, hypertension

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Diabetic Patients (most recent)

Blood Sugar: _____ mg/dl HbA1C: _____ %

fasting or random

Allergy History

Reaction Date	Allergy	Reaction

Medication

Drug	Mg Strength	Reason for medication

Eye Diseases

Disease			If Yes, which eye?
Amblyopia	O Yes	O No	
Blepharitis	O Yes	O No	
Blindness	O Yes	O No	
Cataract	O Yes	O No	
Color Blindness	O Yes	O No	
Diabetic Retinopathy	O Yes	O No	
Dry Eye Symptoms	O Yes	O No	
Eye Injuries	O Yes	O No	
Glaucoma	O Yes	O No	
Glaucoma Suspect	O Yes	O No	
High Risk Medication	O Yes	O No	
Macular Degeneration	O Yes	O No	
PVD	O Yes	O No	
Retinal Detachment	O Yes	O No	
Strabismus (eye turn)	O Yes	O No	

Other _____

Current Eye Symptoms

Symptom			If Yes note which eye and when it began or details
Glare Sensitivity	O Yes	O No	
Headaches	O Yes	O No	
Light Sensitivity	O Yes	O No	
Tired Eyes	O Yes	O No	
Burning	O Yes	O No	
Dryness	O Yes	O No	
Epiphora (Tearing)	O Yes	O No	
Eyelid Swelling	O Yes	O No	
Eye Pain or Soreness	O Yes	O No	
Foreign Body Sensation	O Yes	O No	
Infection of Eye Lid	O Yes	O No	
Itching	O Yes	O No	
Mucous	O Yes	O No	
Drooping Eye Lid	O Yes	O No	
Redness	O Yes	O No	
Sandy or Gritty Feeling	O Yes	O No	

Visual Symptoms

Blurred Vision Distance	O Yes	O No	
Blurred Vision Near	O Yes	O No	
Distorted Vision	O Yes	O No	
Double Vision	O Yes	O No	
Flashes of light	O Yes	O No	
Floaters or Spots	O Yes	O No	
Fluctuating Vision	O Yes	O No	
Loss of Central Vision	O Yes	O No	
Loss of Side Vision	O Yes	O No	
Loss of Vision	O Yes	O No	

Other _____

Constitutional Symptoms

Fever	O Yes	O No
Fatigue	O Yes	O No
Sleep disorder/ CPAP	O Yes	O No

Other _____

Ear, Nose, Throat, Mouth

Hearing loss	O Yes	O No
Sinus disorder	O Yes	O No

Other _____

Cardiovascular

Atrial Fibrillation	O Yes	O No
Heart Disease	O Yes	O No
Hypertension	O Yes	O No
Stroke/ TIA	O Yes	O No

Other _____

Skin

Herpes	O Yes	O No
Rash/ Itching	O Yes	O No
Rosacea	O Yes	O No
Shingles	O Yes	O No
Skin Cancer	O Yes	O No

Other _____

Neurological

Multiple Sclerosis	O Yes	O No
Frequent Headaches	O Yes	O No
Convulsions/ Seizure	O Yes	O No

Other _____

Respiratory			**Psychiatric**		
Asthma	O Yes	O No	Memory Loss	O Yes	O No
Emphysema/ COPD	O Yes	O No	Depression	O Yes	O No
Shortness of breath	O Yes	O No	Other		
Other			**Endocrine**		
Gastrointestinal			Diabetes	O Yes	O No
Intestinal conditions	O Yes	O No	Thyroid Disease	O Yes	O No
Other			Other		
Urinary			**Blood**		
Flomax Use	O Yes	O No	Anemia	O Yes	O No
Kidney Disease	O Yes	O No	Cholesterol	O Yes	O No
Urinary conditions	O Yes	O No	Other		
Urinary symptoms	O Yes	O No	**Allergic/ Immunologic**		
Other			Season Allergies	O Yes	O No
Musculoskeletal			Lupus	O Yes	O No
Arthritis	O Yes	O No	Other		
Muscle/Joint/Back Pain	O Yes	O No			
Other					
			Pregnant	O Yes	O No
Last Health Exam			Nursing	O Yes	O No

Family History

Eye Disease			**Relationship to Patient**
Amblyopia (Lazy Eye)	O Yes	O No	
Blindness	O Yes	O No	
Cataract	O Yes	O No	
Color Blindness	O Yes	O No	
Eye Tumors	O Yes	O No	
Glaucoma	O Yes	O No	
Glaucoma Suspect	O Yes	O No	
Macular Degeneration	O Yes	O No	
Retinal Detachment	O Yes	O No	
Strabismus (Eye Turn)	O Yes	O No	
Other Eye Conditions			
Systemic Diseases			
Arthritis	O Yes	O No	
Cancer	O Yes	O No	
Diabetes	O Yes	O No	
Heart Disease	O Yes	O No	
High Blood Pressure	O Yes	O No	
Kidney Disease	O Yes	O No	
Lupus	O Yes	O No	
Stroke	O Yes	O No	
Thyroid Disease	O Yes	O No	
Other Diseases			

General Social History

Occupation _____ **Yrs** _____ **Employer** _____

Do you drink alcohol? O No O Occasional O 1 per day O 2-3 per day O 4+ per day

Do you smoke? O No O Occasional O 1/2 pk per day O 1 pk per day O 1+ pk per day

Past Smoker? O Yes O No When did you quit? _____

Do you chew tobacco? O Yes O No

Do you use illegal drugs? O Yes O No

Do you use nutritional supplements (vitamins, etc.)? O Yes O No

Do you engage in regular exercise? O Yes O No

Vision Social History

Do you use the computer? O Yes O No

Do you drive? O Yes O No

Have visual difficulty when driving? O Yes O No

Do you have a problem with glare? O Yes O No

Have any problems with night vision? O Yes O No

Spectacles

Do you currently wear glasses? O Yes O No Since _____

O Full Time O Part Time O Distance O Close

Glasses Owned

O Single Vision	O Safety Glasses	O Bifocals	O Sports Glasses
O Trifocals	O Progressives	O Back-up glasses	O Other_____

Have you had trouble in the past with glasses? O Yes O No

If yes, please explain? _____

Do you wear sunglasses? O Yes O No

Are your sunglasses your current prescription? O Yes O No

Do you need special eyewear?

O Computer O Safety Glasses O Occupational O Sports/ Hobbies

Contact Lenses

Have you tried to wear contact lenses? O Yes O No

Reason for stopping: _____

If not a contact lens wearer, are you interested in trying contact lenses at this time? O Yes O No

Do you currently wear contact lenses? O Yes O No Since: _____

Brand of contact lenses _____

How many hours a day do you wear them? _____ hrs/ day

How many days per week ? _____ days/ week

How long do you wear your contact lenses before you toss it and put a fresh one in? _____

What contact lens solution do you use? _____

Please rate the following on a scale of 1-10, with 1 being POOR and 10 being EXCELLENT

	Right	Left		Right	Left
Comfort	_____	_____	Distance Vision	_____	_____
Near Vision	_____	_____			