

ESTABLISHED PATIENT QUESTIONNAIRE

Patient Name: _____ Preferred Phone: _____
 Birthdate: ____/____/____ Other Phone: _____
 Address: _____ Email: _____
 City: _____ State: _____ Zip: _____ Gender (circle): Female Male
 Guardian (if applicable) _____ Occupation _____

Circle appropriate selection: Minor Single Married Divorced Widowed Separated

Race/Ethnicity: _____ Preferred Language: _____

Primary Care Physician/Office: _____ Date of last visit: _____

(Office use only) Patient Number: _____

List any new medications you are taking (include oral contraceptives, aspirin, over-the-counter medication, & home remedies):

Do you have any new allergies to medication? No Yes If yes, explain: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV/AIDS Syphilis

Ocular History: Please check reason(s) for visit

	No	Yes	Unsure		No	Yes	Unsure
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Yes" to any of the above, or have a condition not listed, please explain and list medications/drops:

Any changes to your family's medical or ocular history:
