Davis Hawley Eyecare
Patient History Questionnaire

Please complete a new questionnaire every 3 years and an update at every exam
PLEASE DO NOT WRITE UPDATES ON THIS FORM

Date _____ [please do not use any nicknames or abbreviations, but rather your legal name]:

Patient Last Name _____ First Name _____ Middle Initial _____

I would like the doctor and staff to call me (say my name as): _____

Street Address _____ City _____ State____ ZIP _____

E-mail address _____

Whom may we thank for referring you, or, how did you find our office? _____

Home phone: _____ Work Phone _____ Cell Phone _____

SSN (if requested by front desk)_____ Date of Birth _____ Occupation _____

Employer _____ Date of Last Eye Examination _____

Previous Eye Doctor and location _____

Present Family Physician or Internist and location _____

Does the patient have any physical, intellectual, or emotional disability, English language difficulty, communication problem, or hearing impairment that will require any special accommodation (e.g., unusual amount of extra time for examination by the doctor, need for a translator, or need for special testing?) □ No □ Yes (explain) _____

Are you pregnant? □ No □Yes Are you nursing? □ No □Yes

If patient is under 18 years old, name of parent(s) or guardian(s) _____

Reason(s) for today's visit: (Please BRIEFLY explain the problem(s) that bring you to our office today):

_____

Current **Medications**: (Please list any medications including eye drops, injections, nutritional supplements, and/or vitamins that you take).
□ None

Name of Medication, Eye drop, Injection, Supplement, or Vitamin (if you do not have a list, please ask for our list of the most common medications to assist in correct spelling)	Dose (e.g. 200 mg)	Frequency (e.g., pills per day or uses per day) (e.g. 2x per day)	Route of Administration [oral, nasal,IV,IM, inhaler,subcutaneous, transdermal, rectal, vaginal, otic(ear)]	Condition or Disease for which Medication is Being Taken

Medication / Drug / Food **Allergies** with reactions: □ None

Substance	Reaction

Eye Surgeries / Laser Treatments □ None

Type of Surgery (eg LASIK, cataract, etc.)	Date of Procedure (operation or laser)	Complications, if any

Personal Eye Information

History of eye injury □ No □ Yes If yes, details including date: _____

Have you been told you have or had:

Glaucoma or glaucoma suspect	□ No	□ Yes
Cataract	□ No	□ Yes
Dry Eye	□ No	□ Yes
Herpes virus infection of eye	□ No	□ Yes
Retinal detachment	□ No	□ Yes
Macular Degeneration	□ No	□ Yes
Retinal disease	□ No	□ Yes
Conjunctivitis	□ No	□ Yes
Uveitis	□ No	□ Yes
Corneal ulcer	□ No	□ Yes

Do you wear eyeglasses: [now or in the past year] □ No □ Yes

Do you wear contact lenses: [now or in the past year] □ No □ Yes

Are you currently being treated, or have you at any time in the past been treated, for any **eye** disease or disorder? [surgical eye treatments should be listed in the appropriate section above only] □ No □ Yes

If yes to the above question, please explain: _____
_____

Social History

Do you currently use:

Tobacco □ No □ Yes (including smokeless tobacco)

Have you **ever** used:

Intravenous Drugs (other than as administered by a doctor, EMT, nurse or hospital) □No □Yes

Children □No □Yes Number _____

Hobbies / Special Interests: _____

Past *Personal* Medical History: (Please mark any of the conditions that you currently have or previously had and in the space provided please make a short note about the condition as you experienced it including when you had the problem or how long you had the problem.)

□ None

Diabetes: □ No □Yes (□ insulin; □ no insulin) Year diagnosed: _____ Last A1C number _____

Allergies	□ No □Yes _____	Osteoporosis	□ No □Yes _____
Alzheimer's / Dementia	□ No □Yes _____	Night Sweats	□ No □Yes _____
Anemia / Bleeding Problems	□ No □Yes _____	Heart Problems	□ No □Yes _____
Arthritis (osteo, rheumatoid)	□ No □Yes _____	Hepatitis A, B, or C	□ No □Yes _____
Asthma/Bronchitis	□ No □Yes _____	High Blood Pressure	□ No □Yes _____
Blindness	□ No □Yes _____	High Cholesterol	□ No □Yes _____
Blood Transfusion	□ No □Yes _____	HIV / AIDS	□ No □Yes _____
Cancer	□ No □Yes _____	Lupus	□ No □Yes _____
Depression	□ No □Yes _____	Migraine	□ No □Yes _____
Emphysema/COPD	□ No □Yes _____	Sickle Cell Anemia	□ No □Yes _____
Epilepsy/Seizures	□ No □Yes _____	Stroke	□ No □Yes _____
Glaucoma	□ No □Yes _____	Thyroid Disease	□ No □Yes _____
Kidney/Urinary Problem	□ No □Yes _____	Tuberculosis (TB)	□ No □Yes _____
Ulcer/Stomach Problem	□ No □Yes _____	Other_____	□ No □Yes _____

Family Medical and Eye History: (in the space provided, please indicate relationship.)

KEY: Mom=Mom, Dad=Dad, B=brother, S=sister, Son=Son, Dau=Daughter, M=maternal, P=Paternal; C=Cousin, A=Aunt, U=Uncle

Anemia	□ No □Yes _____	Heart Disease	□ No □Yes _____
Arthritis	□ No □Yes _____	Hepatitis	□ No □Yes _____
Bleeding Problem	□ No □Yes _____	High Blood Pressure	□ No □Yes _____
Blindness	□ No □Yes _____	Macular Degeneration	□ No □Yes _____
Cancer	□ No □Yes _____	Migraine/Headache	□ No □Yes _____
Cataract	□ No □Yes _____	Retinal Detachment	□ No □Yes _____
Corneal Problem	□ No □Yes _____	Sickle Cell Anemia	□ No □Yes _____
Diabetes	□ No □Yes _____	Stroke	□ No □Yes _____
Emphysema	□ No □Yes _____	Thyroid Disease	□ No □Yes _____
Epilepsy/Seizure	□ No □Yes _____	Tuberculosis (TB)	□ No □Yes _____
Glaucoma	□ No □Yes _____	Other	□ No □Yes _____

Please turn over and complete back page. Thank you for your patience and cooperation!

REVIEW OF SYSTEMS

Name of Patient:_____ **Date Completed** _____

Please CHECK if you are experiencing any of the following symptoms

Health in general: □ Chills □Fatigue □Fever □Weight Gain □ Weight Loss
□ Other _____ □ NONE

Skin: □ excessive dryness □ itching □ skin lesion □rash (eczema, psoriasis, rosacea)
□ Other _____ □ NONE

Ears, Nose, Mouth, Throat: □ Sinus pain □ ear discharge □ ear pain □ hearing loss
□ tinnitus (ringing/buzzing/swoosh) □ nasal congestion □ nosebleeds □ rhinorrhea (runny nose)
□ hoarseness □ sore throat □Other _____ □ NONE

Cardiovascular: □ Chest pain □ claudication (leg pain/cramping) □ dyspnea on exertion (shortness of breath with effort) □ leg swelling □ orthopnea (shortness of breath while laying down) □ palpitations
□ Other _____ □ NONE

Respiratory: □ Cough □ hemoptysis (coughing up blood) □shortness of breath □ sputum production
□ wheezing □ sleep apnea (CPAP Y/N) □Other _____□ NONE

Gastrointestinal: □ Abdominal pain □ belching □ blood in stool □ constipation □ diarrhea
□ heartburn □ hemorrhoids □ nausea □ trouble swallowing □ vomiting
□ Other _____ □ NONE

Genitourinary: □ Irregular menses □ bladder incontinence □ polyuria(frequent urination)
□dysuria (painful urination) □ Other _____ □ NONE

Muscle, Joint and Bone: □ Back pain □ falls □ joint pain □ myalgia (muscle pain) □ neck pain
□ Other _____ □NONE

Neurological: □ Dizziness □ focal weakness □ headache □ loss of consciousness □ seizures
□ speech change □ numbness/tingling □ tremor □ Other_____ □ NONE

Psychiatric: □ Depression □ hallucinations □ insomnia □ memory loss □ nervous/anxious
□ Other _____ □ NONE

Allergic/ Immunology: □ Environmental allergies □ Other _____ □ NONE

Blood and Lymph: □ Easy bruise/ bleed □ lymph node swelling
□ Other _____ □ NONE

Glands and Endocrine: □ Hot flashes □ polydipsia (frequent thirst) □ excessive sweating
□ Other _____ □ NONE