WRIGHT EYE CARE CENTER

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HEALTH HISTORY QUESTIONNAIRE

*Name:*_____ *Date:*_____ *D.O.B.*_____

*Best #:*_____ *Last Eye Exam:*_____ *By Dr.:*_____

*Pharmacy:*_____ *Pharmacy Phone #:*_____

Medical History & General Health

Do you feel that your general health is ❍ Good ❍ Fair ❍ Poor

Are you allergic to any medications ❍ Yes ❍ No Known Please list _____

List any medications here (❍ *List provided*) _____

Height_____ Weight_____ Are you Pregnant /Nursing ❍ Yes ❍ No

List major surgeries or illnesses: _____

Eye History

Are you experiencing any of the following symptoms? Please check.

❍ Blurred Vision	❍ Double Vision	❍ Sty	❍ Tearing	❍ Dryness
❍ Flashes/Floaters	❍ Glare	❍ Eye Lid Itch	❍ Light sensitivity	❍ Discharge
❍ Variable Vision	❍ Droopy Eyelid(s)	❍ Eyeball Itch	❍ Eye Pain	❍ Foreign Body Sensation
❍ Distorted Vision	❍ Loss of Lashes	❍ Sting, Burn	❍ Redness	❍ Other_____

Have you had any eye surgery, laser treatments or eye injury: ❍ YES ❍ NO *If yes, please list:* _____

_____

When do you wear your glasses? ❍ All the time ❍ Computer ❍ Reading/Near ❍ Distance only ❍ Other _____

*How old is this prescription?*_____ *Do you see well with this prescription?* ❍YES ❍NO

Do you wear contacts? ❍YES ❍NO Brand of contacts if known:_____

Are you interested in contacts? ❍YES ❍NO Are you interested in laser vision correction ❍YES ❍NO

Review of Systems

Place check beside the following that apply or mark NONE below:

❍ **Constitutional**
Fever, Weight gain/loss

❍ **Ear/Nose/Throat**
Hearing loss, Sinus

❍ **Neurological**
Migraines

❍ **Endocrine**
Thyroid/other glands

❍ **Respiratory/Pulmonary**
Asthma, Bronchitis

❍ **Cardiovascular, Vascular**
Blood pressure

❍ **Gastrointestinal**
Colitis, Crohns disease

❍ **Genitourinary**
Bladder/Prostate

❍ **Bones/Joints**
Joint Pain/Arthritis

❍ **Lymphatic/Hematologic**
Anemia/Bleeding

❍ **Allergic/Immunologic**
Sjogrens

❍ **Psychiatric**
Depression

❍ **NONE**

Personal History

Do you smoke: ❍ YES ❍ NO ❍ Did but quit

Have you been infected with:
❍ Hepatitis ❍ Herpes Simplex ❍ HIV ❍ COVID ❍ None

Race:
❍ White ❍ African American/Black ❍ Asian
❍ Hispanic ❍ I decline to specify ❍ Other

Ethnicity:
❍ Hispanic ❍ Not Hispanic ❍ I decline to specify

Preferred Language:
❍ English ❍ Spanish ❍ I decline to specify

Family History

Do you or a blood relative have:

	Self		Relative	
Glaucoma	❍ YES	❍ NO	❍ YES	❍ NO
Cataracts	❍ YES	❍ NO	❍ YES	❍ NO
Lazy Eye	❍ YES	❍ NO	❍ YES	❍ NO
Retinal Disease	❍ YES	❍ NO	❍ YES	❍ NO
Macular Degeneration	❍ YES	❍ NO	❍ YES	❍ NO
Corneal Disease	❍ YES	❍ NO	❍ YES	❍ NO
Hypertension	❍ YES	❍ NO	❍ YES	❍ NO
Cancer	❍ YES	❍ NO	❍ YES	❍ NO
COPD	❍ YES	❍ NO	❍ YES	❍ NO
Arthritis	❍ YES	❍ NO	❍ YES	❍ NO
Diabetes	❍ YES	❍ NO	❍ YES	❍ NO
Asthma	❍ YES	❍ NO	❍ YES	❍ NO