WRIGHT EYE CARE CENTER

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wrighteye2020.com

PATIENT QUESTIONNAIRE

Full Name: _____ Birth Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Occupation: _____ Employer: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Primary Care Doctor: _____ Primary Phone: _____

Whom may we thank for referring you to our office: _____

OCULAR HISTORY

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ No ☐ Yes If yes, what type? ☐ Rigid ☐ Soft ☐ Toric ☐ Multifocal ☐ Monovision ☐ Extended Wear

Do you wear them ☐ Full Time ☐ Part Time How frequently do you replace them? _____

Have you had refractive surgery? ☐ No ☐ Yes If yes, Date _____ Type _____

What other services would you like to be evaluated for? ☐ Refractive Surgery ☐ Contact Lenses ☐ Computer Glasses ☐ Reading Glasses ☐ Sunglasses ☐ Driving Glasses

Are you having any visual difficulties? ☐ No ☐ Yes If yes, please explain: _____

Are you currently experiencing any of the following problems with your eyes? Check the box if "Yes."

☐ Blurred Vision	☐ Flashes / Floaters in Vision	☐ Redness
☐ Loss of Vision	☐ Halos / Glare / Light Sensiitivity	☐ Excess Tearing / Watering
☐ Loss of Side Vision	☐ Dryness	☐ Eye Pain or Soreness
☐ Distorted Vision	☐ Sandy or Gritty Feeling	☐ Mucous Discharge
☐ Double Vision	☐ Burning	☐ Inflammation of the Eyelid
☐ Tired Eyes	☐ Itching	☐ Styes or Chalazion

Have you been diagnosed with any of the following ocular problems? Check the box if "Yes."

☐ Cataracts	☐ Crossed Eyes	☐ Eye Injury
☐ Glaucoma	☐ Lazy Eye / Amblyopia	☐ Macular Degeneration
☐ Retinal Detachment / Disease	☐ Dry Eye	☐ Other _____

MEDICAL HISTORY

List any medications you are currently taking (include oral contraceptives, aspirin, over the counter medications):

_____

_____

_____

Are you allergic to any medications? ☐ No ☐ Yes If yes, which ones: _____

List all major surgeries you have had: _____

_____

REVIEW OF SYSTEMS *Please check the box beside any problem you currently have, or have had, in the following areas:*

ALLERGIC / IMMUNOLOGIC ☐ All Normal
- ☐ Allergy / Hay Fever

CARDIOVASCULAR / CARDIAC ☐ All Normal
- ☐ Arteriosclerosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol

CONSTITUTIONAL ☐ All Normal
- ☐ Fever
- ☐ Weight Loss / Gain

EARS, NOSE, MOUTH, THROAT ☐ All Normal
- ☐ Sinus Congestion
- ☐ Dry Throat / Mouth

ENDOCRINE ☐ All Normal
- ☐ Diabetes
- ☐ Throid Disease
- ☐ Chronic Fatigue

GASTROINTESTINAL ☐ All Normal
- ☐ Diarrhea / Constipation
- ☐ IBS / Crohn's Disease
- ☐ Ulcers
- ☐ Reflux

GENITOURINARY ☐ All Normal
- ☐ Kidney Disease
- ☐ Ovarian / Uterine Cancer
- ☐ Prostate Cancer

HEMATOLOGIC / LYMPHATIC ☐ All Normal
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Breast Cancer

INTEGUMENTARY (Skin) ☐ All Normal
- ☐ Cancer
- ☐ Rashes
- ☐ Easy Bruising

MUSCULOSKELETAL ☐ All Normal
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint Pain

NEUROLOGICAL ☐ All Normal
- ☐ Migraines
- ☐ Dizziness
- ☐ Seizures
- ☐ Stroke

PSYCHIATRIC ☐ All Normal
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss
- ☐ Hallucinations

RESPIRATORY ☐ All Normal
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Cough

If you checked any of the above boxes or have a condition not listed, please explain further: _____

_____

_____

Are you pregnant and / or nursing? ☐ No ☐ Yes

Do you feel your general health is ☐ Good ☐ Fair ☐ Poor

PERSONAL HISTORY

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

Have you been infected with: ☐ Hepatitis ☐ HIV
☐ Herpes Simplex ☐ 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

Height_____ Weight_____

FAMILY HISTORY *Please note any family history (parents, grandparents, siblings, children; living or deseased) for the following conditions:*

	RELATION TO YOU		RELATION TO YOU
☐ Glaucoma	_____	☐ Diabetes	_____
☐ Cataract	_____	☐ Cancer	_____
☐ Macular Degeneration	_____	☐ Heart Disease	_____
☐ Retinal Detachment	_____	☐ High Blood Pressure	_____
☐ Blindness	_____	☐ Kidney Disease	_____
☐ Crossed Eyes	_____	☐ Lupus / Arthritis	_____

Signature: _____ Date ____/____/____