



HARDBERGER | LIEBLONG

Eye Center

Patient History Questionnaire

Name _____ Birth Date _____

Name of Referring Physician _____ Physician Phone _____

Physician Address _____ Date of Last Eye Exam _____

History of Present Illness (elements):

___ Location ___ Quality ___ Severity ___ Modifying Factors
___ Timing ___ Duration ___ Context ___ Associated Signs & Symptoms

REVIEW OF

Do you currently have any problems in the following areas? If “yes”, provide information.

	YES	NO	Explanation of Problem
Constitutional Symptoms			
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted Vision (halos)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	_____
Occasional Tearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Infection of Eye/Lid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sties, Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluctuating Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____

	YES	NO	Explanation of Problem
Ears, Nose, Mouth, Throat			
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular (heart/blood vessels)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (lungs/breathing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (Stomach/intestines)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary			
(genitals/kidney/bladder)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integumentary (skin and/or breast)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemotalogic/Lyphatic			
Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lyph nodes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/Immunologic			
Head Allergy Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay Fever Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____

PAST

List any medications you currently take

List all major illnesses and injuries _____

List any surgeries you have had _____

Have you had crossed eyes, lazy eye, drooping eyelid, prominent eyes?

Do you have allergies to any medications? YES NO

If YES, list medications _____

FAMILY

	YES	NO	Relationship to Patient
DISEASE			
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attacks	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sjogrens Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL

Current Occupation _____

Do you drive? YES NO

Do you have visual difficulty when driving? YES NO

Do you have problems with night vision? YES NO

Have you ever tried to wear contacts? YES NO

Do you currently wear glasses? YES NO

If YES, how long have you had the current prescription? _____

Do you drink alcohol? YES NO

If YES, how often? _____

Do you smoke? YES NO

If YES, how many packs a day? _____

Have you ever had a blood transfusion? YES NO

Have you ever been in intimate contact with a person who had a sexually transmitted disease? YES NO

History reviewed. No changes. Additions as noted above.

Physician's Signature: _____ Date: _____