Dr. Ana Lopez

# Patient History Questionnaire

Date____________

Name: ______________________________ Phone: ______________________

Address: ______________________________________________________

SS#_____-_____-________ Email: ___________________________________

Birth Date: ____/____/_____ Medical Doctor: ________________ Doctor's Phone: ______________

Medical Insurance: ______________________ Vision Insurance: ______________________

Last Medical Exam ____________ Last Eye Exam ____________

How did you hear about us? ________________________________________

*(Payment is expected at check-in)*

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## Ocular History

Do you Wear glasses? ☐ Y ☐ N If yes, how old are your current lenses? ______________

Do you wear contact lenses? ☐ Y ☐ N If yes, how old are your current lenses? ____________

Type of contact lenses? ☐ Soft ☐ Rigid ☐ Extended Wear ☐ Toric ☐ Multifocal ☐ Monovision ☐ Other

Do you wear them ☐Full Time ☐ Part Time Are they comfortable? ☐ Y ☐ N

Have you had refractive surgery? (Lasik) ☐ Y ☐ N If yes, Date ______________ Type________________

**WHAT SERVICES WOULD YOU LIKE TO BE EVALUATED FOR TODAY?**

☐ **Contact Lenses** ☐ **Glasses** ☐ **Refractive surgery (Lasik)**

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## Medical History

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

________________________________________________________________

________________________________________________________________

Are you allergic to any medications? ☐ Y ☐ N If so, which ones: ______________________

List any major injuries, surgeries and or hospitalizations you have had: ______________________

________________________________________________ Are you Pregnant? ☐ Y ☐ N

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**Check any health problems that apply to YOU:** ***(present or past)*** ☐ **None**

☐ Anxiety ☐ Arthritis ☐ Asthma ☐Cancer ☐COPD ☐ Coronary Artery Disease ☐ Diabetes ☐GERD

☐ Hearing Loss ☐ Hepatitis ☐ High Blood Pressure ☐ HIV/AIDS ☐ High Cholesterol ☐ Hyperthyroidism

☐ Hypothyroidism ☐ Seizures/ Stroke ☐ Heart Attack ☐ Lupus Other______________________

**Check any Eye problems that apply to YOU:** ***(present or past)*** ☐ **None**

☐ Glaucoma ☐ Cataracts ☐ Retinal Detachment ☐ Macular Degeneration ☐ Crossed-Eye ☐ Lazy-Eye

☐ Drooping Eyelids ☐ Blindness ☐ Eye Infections ☐ Eye Injury ☐ Other____________________

**Family History** Please list any family members with the following conditions:
*(parents, grandparents, siblings, children; living or deceased)* □ **None**
Blindness, Cataract, Glaucoma, Diabetes, Macular Degeneration, Retinal Detachment, Cancer, High Blood Pressure, Heart Disease, Lupus: ______________________________

______________________________

**Social History** (*this information is strictly confidential*)

Do you drive? ☐ Y ☐ N If yes do you have visual difficulty when driving? ☐ Y ☐ N
If yes, please describe ______________________________

Do you use tobacco products? ☐ Y ☐ N If yes, amount/ how long: ____________________

Do you drink alcohol? ☐Y ☐ N If yes, amount/ how long: ____________________

Do you use drugs? ☐ Y ☐ N If yes, type/amount/ how long: ____________________

**Review of Systems and complaints (please check all that apply to you)** □ **None**

**Eyes**
- □ Dryness
- □ Sandy Gritty Feeling
- □ Burning
- □ Itching
- □ Redness
- □ Tearing/Watering
- □ Eye Pain/Soreness
- □ Mucous Discharge
- □ Flashes/ Floaters
- □ Halos
- □ Loss of Vision
- □ Loss of Side Vision
- □ Double Vision
- □ Blurred Vision
- □ Glare/Light sensitivity

**Constitutional**
- □ Fever
- □ Weight Loss/Gain

**Integumentary/ Hematologic**
- □ Skin Disease
- □ Anemia
- □ Cancer
- □ Scalp Tenderness

**Neurological**
- □ Headaches
- □ Migraines
- □ Seizures

**Ears, Nose, Throat**
- □ Dry Throat/Mouth
- □ Congestion Runny Nose
- □ Allergies/Hay Fever

**Respiratory**
- □ Chronic Cough
- □ Bronchitis
- □ Asthma
- □ Emphysema

**Psychiatric**
- □ Anxiety
- □ Depression

**Musculoskeletal**
- □ Rheumatoid Arthritis
- □ Muscle Pain
- □ Join Pain

**Gastrointestinal**
- □ IBS/ Crohn's Disease
- □ Diarrhea
- □ Constipation

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**FOR OFFICE USE ONLY**

Outside Referral: Y N ☐ Sunrise (Evans) ☐ Adelante ☐ Other ____________________
Pharmacy ____________________

| Impressions: | FE | Plan: | Follow Up: |
|---|---|---|---|
| 1. | | 1. | 1. |
| 2. | | 2. | 2. |
| 3. | | 3. | 3. |
| 4. | | 4. | 4. |
| 5. | | 5. | 5. |
| 6. | | 6. | 6. |
| CD Ratio | | OD: | OS: |

| Specs | Sphere | Cylinder | Axis | Add | Prism | CL | Sphere | Cylinder | Axis | Add | Prism |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Final Rx OD | | | | | | Final Rx OD | | | | | |
| Final Rx OS | | | | | | Final Rx OS | | | | | |

Referral: Sunrise ECNC Other ____________________ For: ______________ Faxed ______
Notes: ______________________________