



# Evelyn Marie Moore, O.D., P.C.

DOCTOR OF OPTOMETRY

## PATIENT HISTORY QUESTIONNAIRE

The information in this confidential case history form is critical to the evaluation of your vision and health.

### Patient General Medical History

Date of Last Physical Check-up \_\_\_\_\_ Name of Family Physician \_\_\_\_\_ Town \_\_\_\_\_

Please check any of the following health conditions for which you have been diagnosed and/or are being treated:

- Allergies     Bronchitis     Cancer     High Cholesterol     Cardiovascular Disease     Depression
- Diabetes Type I     Diabetes Type II     Digestive Disorders     Eczema/Rashes     Gastrointestinal
- High Blood Pressure     Kidney     Muscle Bone     Neurological     Psychological     Respiratory
- Sinus     Thyroid     Unusual weight losses/gains     Frequent Headaches     Other

### Patient Eye History

Date of Last Eye Exam \_\_\_\_\_ by Dr. \_\_\_\_\_ at \_\_\_\_\_

Do you wear glasses? Y N When?  Constantly  Reading Only  Driving  TV  Other \_\_\_\_\_

Do you use any of the following?  Prescription Sunglasses  Computer Glasses  Safety Glasses  Other \_\_\_\_\_

Do you wear contact lenses? Y N What Kind? \_\_\_\_\_ Number of hours worn per day \_\_\_\_\_

How often do you replace your contact lenses? \_\_\_\_\_ days/weeks/months

Which brand of care system do you use? \_\_\_\_\_

Would you like to be fit with contact lenses today? Y N

Please check any of the following eye conditions for which you have been diagnosed or are being treated:

- Seasonal Eye Allergies     Chronic Eye Allergies     Cataract     Corneal Problems     Dry Eyes
- Eye Injuries \_\_\_\_\_  Iritis     Glaucoma     Optical Migraines     Optic Neuritis
- Retinal/Macular problems     Retinal Detachment     Other \_\_\_\_\_

### Current Medications and Allergies to Medicine

Medication/Herbs/Vitamins	Condition Treated	Allergies to Medicine

### Patient Social History

Time spent at computer monitor: \_\_\_\_\_ Hours/day

Time spent outdoors \_\_\_\_\_ hours/week

The ages of my dependent children are \_\_\_\_\_

List eye safety needs \_\_\_\_\_

Night Vision Problems \_\_\_\_\_

Lifestyle: \_\_\_\_\_

Occupation Vision Needs \_\_\_\_\_

Sports \_\_\_\_\_

Hobbies \_\_\_\_\_

Tobacco use: None Occasional \_\_\_\_\_ per day

Alcohol use: None Occasional \_\_\_\_\_ Drinks per day

### Family Medical/Ocular History

Please check all conditions that are in your immediate family history (Grandparents, Parents, Siblings, Children):

- Blindness     Cataracts     Corneal Problems     Diabetes     Glaucoma     Heart Disease
- Lazy Eye     Macular Degeneration     Retinal Problems     High Blood Pressure

Signature X \_\_\_\_\_

Date \_\_\_\_\_