



PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name _____ First Name _____ MI _____
 Address _____ City _____ State _____ Zip _____
 Work Phone _____ Home Phone _____
 Date of birth _____ Occupation _____ Employer _____
 Emergency Contact Name _____ Phone Number _____
 Date of Last Eye Exam _____ Dilated? Yes / No Referred By: _____
 Primary Vision Coverage _____ Secondary Coverage _____

Medical Information

What is your general health? _____
 Do you have problems with any of these systems? (Please circle yes or no.)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain _____
 Diabetes Yes/No Type _____ Date of diagnosis _____
 Allergies to Medication Yes/No Which? _____ Reactions? _____
 Other health problems _____
 Current medication(s) _____
 Have you had any operations? Yes/No Kind? _____ When? _____
 Name of family doctor _____
 Date of last visit _____ Date of last tetanus shot _____

Family History

High blood pressure	Yes/No	Relation _____	Macular degeneration	Yes/No	Relation _____
Diabetes	Yes/No	Relation _____	Retinal detachment	Yes/No	Relation _____
Glaucoma	Yes/No	Relation _____	Cataracts	Yes/No	Relation _____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? _____
 Have you had any eye operations? Yes/No Type _____ Date _____
 Have you had an eye injury? Yes/No Kind _____ Date _____
 Do you have glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No
 Macular degeneration? Yes/No Retinal detachment? Yes/No Blurred vision? Yes/No
 Do you wear glasses? Yes/No Contact lenses? Yes/No Type _____
 Additional information _____

Doctor Use Only

Reviewed by _____ No changes Date _____
 Reviewed by _____ No changes Date _____
 Reviewed by _____ No changes Date _____

PATIENT LIFESTYLE QUESTIONNAIRE

Provided by your
VSP Network Doctor

EYEWEAR

- 1) Do your glasses sometimes irritate your face? Yes No
- 2) If you could, would you prefer not to wear glasses? Yes No
- 3) Are you satisfied with the way your glasses look and feel? Yes No
- 4) Are you satisfied with the vision and comfort your glasses provide? Yes No
- 5) If your glasses were lost or destroyed, could you function well at work, at home and with hobbies? Yes No
- 6) Do you wear sunglasses? Yes No
- 7) If you wear bifocals, are you bothered by the lines or do you sometimes tilt your head to see? Yes No

CONTACT LENSES

- 1) How often do you wear your contact lenses? _____
- 2) What cleaning solutions do you use? _____
- 3) Do you experience dry or itchy eyes or dry contacts? Yes No
- 4) Are you interested in contacts that change the color of your eyes? Yes No
- 5) Are you interested in the latest contact lens designs? Yes No

OCCUPATION

What is your occupation? _____

Do you:

- Work at a computer? Yes No
- Work outdoors? Yes No
- Work in a hazardous environment, such as manufacturing? Yes No

LIFESTYLE

What hobbies do you enjoy? (e.g. reading, gardening, woodworking, sewing) _____

What sports activities do you enjoy? (e.g. water sports, snow sports, fishing, hunting, walking/running) _____

How many hours a day do you spend driving? _____

Do you:

- Spend time in areas with low lighting? Yes No
- Drive frequently at dawn, dusk or night? Yes No
- Drive frequently with the sun in your eyes? Yes No

FAMILY

Do you have children? Yes No

If any family members wear eyewear, please indicate so below.

Family member's relationship	Wear eyewear	
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

COMMENTS

Anything else you'd like to share with us? _____

DILATION, PHOTOGRAPHY, & GDxVCC CONSENT

Dilation

- Detects presence of tumors, retinal detachments, and other conditions such as floaters, flashes, or spots
- Due to widening of your pupil, dilation will affect the comfort of many patients when reading and create light sensitivity
- Not all patients can be dilated effectively, and the appropriate potential for dilation will be determined by the doctor during the examination

CHECK ONE (1)

I accept dilation

I decline dilation

Reschedule please

Photography (\$18)

- Picture of the back of the eye
 - Shows nerves, retina, and optic disc
- Detects subtle changes in the retina
- Shows the overall health of the eye
- Dr. Ruiz recommends photography as part of your routine exam

CHECK ONE (1)

Yes, I accept photography today

No photography today, thanks

DGxVCC (\$18)

- We are one of the few offices in Killeen where this technology is available
 - This is the latest in glaucoma detection
 - Detects glaucoma six years ahead of other technologies
- Air-puff pressure check (tonometry) is ineffective for detecting glaucoma in 1/2 of patients diagnosed with the disease
- Glaucoma affects 67 million people worldwide
- For glaucoma patients with three living relatives, the chance that one of them has undiagnosed glaucoma is
 - 27% among Caucasians
 - 50% among African Americans and Hispanics
- The test itself takes only about three seconds per eye
- Dr. Ruiz feels it is vital to screen for this disease as part of a quality eye exam

CHECK ONE (1)

Yes, I accept the GDx testing

No, I will decline the GDx testing

Patient Signature: _____ Date: _____