

**SPOKANE EYE CLINIC HEALTH QUESTIONNAIRE**

*PLEASE PRINT*

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

**Eyes:** *With your glasses or contacts (or without, if you do not wear), do you have any difficulty . . .*

- | YES                      | NO                       | Explanation   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Reading small print (medicine bottles, newspaper, etc.) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Reading traffic or street signs _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Handy work such as sewing, knitting, carpentry, etc. _____    |
| <input type="checkbox"/> | <input type="checkbox"/> | Writing checks or filling out forms _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Driving during the day or with night vision _____             |

- | YES                      | NO                       | Explanation  | YES                      | NO                       | Explanation  |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision _____                                  | <input type="checkbox"/> | <input type="checkbox"/> | Twitching or shaking eye of eyelids _____          |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurry vision uncorrectable by lenses _____          | <input type="checkbox"/> | <input type="checkbox"/> | Crossed, turned, or wandering eye _____            |
| <input type="checkbox"/> | <input type="checkbox"/> | Dimming of vision that comes and goes _____          | <input type="checkbox"/> | <input type="checkbox"/> | Flashes or streaks of light _____                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Sudden loss of vision _____                          | <input type="checkbox"/> | <input type="checkbox"/> | New floaters (spots, strings, or shadows) _____    |
| <input type="checkbox"/> | <input type="checkbox"/> | Red or pink eye _____                                | <input type="checkbox"/> | <input type="checkbox"/> | Discharge, crusting, or excessive tearing _____    |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye pain _____                                       | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of the eye or eyelids _____               |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of side vision _____                            | <input type="checkbox"/> | <input type="checkbox"/> | Bulging of one or both eyes _____                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Haloed (colored rays or circles around lights) _____ | <input type="checkbox"/> | <input type="checkbox"/> | Difference in the size of the eyes or pupils _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry eye _____  | <input type="checkbox"/> | <input type="checkbox"/> | Light sensitivity _____                            |

**REVIEW OF SYSTEMS:** *Do you currently have any problems in the following areas? If yes, please explain.*

**Endocrine** (thyroid/diabetic):

- Thyroid \_\_\_\_\_   Diabetic, date diagnosed: \_\_\_\_\_

**PAST HISTORY:**

Current Medications:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all major illnesses you have had including eyes: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

List all surgeries you have had including eyes: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**MEDICATION ALLERGIES:**  Yes  No If yes, please list:

\_\_\_\_\_

**PERSONAL AND FAMILY EYE HISTORY:**

DISEASE	YES	NO	Relation, (self)	YES	NO	Relation, (self)
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems _____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis _____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (type) _____
Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure _____
Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	Lupus _____
Blind eye	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease _____

**PLEASE TURN OVER AND COMPLETE QUESTIONS ON BACK**

**REVIEW OF SYSTEMS:** *Do you currently have any problems in the following areas? If yes, please explain.*

<b>Constitutional Symptoms:</b>	<b>YES</b>	<b>NO</b>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Ears, nose, mouth, throat:**

<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Teething/Dentition _____	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion _____
<input type="checkbox"/>	<input type="checkbox"/>	Vertigo/Dizziness _____	<input type="checkbox"/>	<input type="checkbox"/>	Post-nasal drip _____
<input type="checkbox"/>	<input type="checkbox"/>	Dry throat/mouth _____			

**Allergic/Immunologic:**

<input type="checkbox"/>	<input type="checkbox"/>	Seasonal allergies/Hay fever symptoms _____
<input type="checkbox"/>	<input type="checkbox"/>	Immune disorders _____

**Cardiovascular:**

<input type="checkbox"/>	<input type="checkbox"/>	Chest pain _____	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart rhythm or pulse _____
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath _____	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Stent placed _____

**Respiratory:**

<input type="checkbox"/>	<input type="checkbox"/>	Chronic bronchitis _____	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	Cough _____

**Gastrointestinal: (stomach/intestines)**

<input type="checkbox"/>	<input type="checkbox"/>	Ulcers _____	<input type="checkbox"/>	<input type="checkbox"/>	Chronic diarrhea _____
<input type="checkbox"/>	<input type="checkbox"/>	Constipation _____	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool _____

**Genitourinary (genitals/kidney/bladder):**

<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ever Taken Prostate Medications _____
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**Musculoskeletal:**

<input type="checkbox"/>	<input type="checkbox"/>	Arthritis or aching joints _____	<input type="checkbox"/>	<input type="checkbox"/>	Back pain _____
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**Integumentary (skin and/or breast):**

<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	Rashes, sores, or blisters _____
			<input type="checkbox"/>	<input type="checkbox"/>	Unusual moles or pigmented lesions _____

**Neurological (nervous diseases):**

<input type="checkbox"/>	<input type="checkbox"/>	Memory loss _____	<input type="checkbox"/>	<input type="checkbox"/>	Seizures _____
			<input type="checkbox"/>	<input type="checkbox"/>	Depression or mood changes _____

**Hematologic/Lymphatic:**

<input type="checkbox"/>	<input type="checkbox"/>	Blood disorder or anemia _____	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion _____
<input type="checkbox"/>	<input type="checkbox"/>	Lymph nodes _____	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding or bruising _____

**SOCIAL HISTORY: YES NO**

Do you drink alcohol?   If YES, how often? \_\_\_\_\_

Do you smoke?   If YES, how many packs a day? \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_