

Advance Eye Care, O.D. PA

Dr. Sarit G. Catchatoorian O.D.

Date _____

Dr. Gurpreet K. Chadha O.D

PATIENT HISTORY QUESTIONNAIRE

Last Name _____ First Name _____ Middle _____

Address _____

City _____ State _____ ZIP _____ Home Phone _____ Cell _____

Date of Birth _____ Age _____ Sex: Male Female

Social Security # _____ Medical Insurance _____ Vision Insurance _____

Occupation _____ Employer _____

Spouse Name _____ DOB _____ Employer _____ Phone _____

Date of Last Eye Exam _____ Were you dilated? YES NO

Email _____ Referred By _____ Hobbies/Interests _____

MEDICAL INFORMATION

DO YOU HAVE ANY PROBLEMS WITH ANY OF THESE SYSTEMS (PLEASE CHECK)

- | | | |
|--|---|---|
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Headaches | <input type="checkbox"/> Muscle/Joint |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Gastrointestinal/Urinary | <input type="checkbox"/> Mental |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Blood/Lymph | <input type="checkbox"/> Seasonal Allergies |

Please explain _____

Other health problems _____

Do you smoke? Yes/No Alcohol? Yes/No If so, how often? _____ Allergies to Med(s) _____

Past Surgery _____ When? _____ Last Physical/Visit _____

Primary Care Doctor _____ Practice Name _____

Current Medication(s) _____

OCULAR HISTORY

- | | | |
|---|---|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Flashes/Floaters |
| <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Eye Allergies |
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Glare/Light Sensitivity |

FAMILY HISTORY

- | | RELATION | | RELATION |
|--|----------|---|----------|
| <input type="checkbox"/> High Blood Pressure | _____ | <input type="checkbox"/> Glaucoma | _____ |
| <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Blindness | _____ |
| <input type="checkbox"/> Stroke | _____ | <input type="checkbox"/> Macular Degeneration | _____ |
| <input type="checkbox"/> Cataract | _____ | <input type="checkbox"/> Retinal Detachment | _____ |

Do you have more than one pair of current RX glasses? YES NO

Do you wear sunglasses outside? YES NO

Do you work on the computer for long periods? YES NO

Do you spend a lot of time outdoors? YES NO

Are there times you'd rather not wear glasses? YES NO

Are you satisfied with your current contact lenses? YES NO

Interested in learning about laser vision correction? YES NO

DOCTOR USE ONLY

REVIEWED BY _____ NO CHANGES DATE _____

REVIEWED BY _____ NO CHANGES DATE _____