Dr. Funnell
Optometry

Health History Form & Lifestyle Questionnaire

Today's Date: ____________________

PATIENT INFORMATION

Patient Name: ______________________________ Date of Birth: ____/____/____

Gender: ☐ Male ☐ Female Height: ______ ft ______ in Weight: _________ lbs

Last Eye Doctor/Location: ______________________________ Date of last eye exam: ____________________

Primary Care Physician/Location: ______________________________ Date of last physical exam: ________________

Pharmacy/Location: ______________________________ Occupation: ____________________

What is the main reason for your visit today? ______________________________

Do you have any other visual/ocular problems? ______________________________

SPECTACLE/CONTACT LENSES

Do you primarily wear glasses? ☐ Yes ☐ No ☐ Full Time ☐ Part Time ☐ Distance Only ☐ Reading Only ☐ Multifocal

How old are your current glasses? ____________________

Do you wear contact lenses? ☐ Yes ☐ No Are you interested in a new contact lens design? ☐ Yes ☐ No

Are you interested in refractive surgery (laser or cataract) options? ☐ Yes ☐ No

COMPUTER USE

How many total hours per day do you use a computer, cell phone, tablet or play video games?

☐ 0-2 hours ☐ 2-4 hours ☐ 4-6 hours ☐ more than 6 hours

Do you use computer glasses? ☐ Yes ☐ No

Are you interested in special glasses to make computer work easier? ☐ Yes ☐ No

SPORTS & LEISURE

What sports/hobbies do you participate in? ______________________________

Do you wear any special eyewear for your sport/hobby? ______________________________

Do you currently wear prescription sunglasses? ☐ Yes ☐ No Are you sensitive to bright lights? ☐ Yes ☐ No

DRY EYE QUESTIONNAIRE

Please check off the following for **SEVERITY** *and* **FREQUENCY** *of dry eye symptoms:*

Severity of Symptoms	0	1	2	3	4
Dryness, grittiness or scratchiness					
Soreness or irritation					
Burning or watering					
Eye Fatigue					

Legend

0 - No problems
1 - Tolerable *(not perfect, but not uncomfortable)*
2 - Uncomfortable *(irritating, but does not interfere with my day)*
3 - Bothersome *(irritating and interferes with my day)*
4 - Intolerable *(unable to perform my daily tasks)*

Frequency of Symptoms	0	1	2	3
Dryness, grittiness or scratchiness				
Soreness or irritation				
Burning or watering				
Eye Fatigue				

Legend

0 - Never
1 - Sometimes
2 - Often
3 - Constant

Office Use Only

Intern Initials ______

Faculty Initials ______

(continued on back)

Please check boxes that apply. Unchecked boxes will mean “no”.

Review of Systems

	Current Symptoms	Yes
Allergy	Seasonal	
	Penicillin	
	Sulfa	
	Neomycin	
	Anesthetic or “Caine” drug	
	Food:	
	Other:	
Constitutional	Unexplained Fever	
	Unexplained Weight Loss	
	Unexplained Fatigue	
Cardiovascular	Chest pain	
	Shortness of breath with exertion	
	Irregular heart beat	
	Low heart rate	
Endocrine	Increase in urination	
	Increase in thirst	
	Increase in appetite	
Gastrointestinal	Constipation	
	Diarrhea	
	Unexplained abdominal pain	
	Vomiting blood	
	Blood in stool	
Genitourinary	Burning while urinating	
	Difficulty urinating	
	Blood in urine	
Head	Persistent sore throat	
	Hearing loss	
	Hoarseness of voice	
	Ear or nose discharge	
	Loss of smell	
	Sinus congestion	
	Difficulty swallowing	
	Mouth ulcers	
Hematologic/ Lymphatic	Swollen glands	
	Anemia	
	Frequent bruising	
Immunologic/ Integumentary (Skin)	History of infectious disease	
	Unexplained skin rashes	
	Persistent itching of skin	
	Eczema of skin	
	Pigmented lesions	
Musculoskeletal	Joint pain	
	Unexplained muscle pain	
	Restriction of motion	
	Lower back pain	
Neurologic	Muscle weakness	
	Tingling in extremities	
	Dizziness	
	Blackouts/Grey outs	
Psychiatric	Ongoing depression	
	Memory lapses	
	Disorientation	
	Dementia	
Respiratory	Shortness of breath	
	Persistent cough	
	Wheezing sounds	

Eye History

Conditions	Yes	Surgeries	Yes
Glaucoma/ Suspect		Cataract	
Cataract		Glaucoma	
Macular degeneration		Retinal Detachment	
Uveitis		LASIK	
Retinal Detachment		Laser	
Eye turn/Lazy Eye		Eyelid	
Trauma		Injections in the eye	
Other:		Other:	

Medical History

	Yes		Yes
Diabetes		Heart Attack	
High blood pressure		Stroke	
Elevated Cholesterol		Cancer	
Thyroid disorder		Asthma/COPD	
Sleep Apnea		Kidney disease	
Pregnant - currently		Arthritis	
Nursing - currently		Other:	

Family History

Ocular	Yes	Medical	Yes
Glaucoma		Diabetes	
Macular degeneration		Hypertension	
Eye turn		Cancer	
Night blindness		Heart disease	
Keratoconus		Migraine	
Other:		Other:	

Social History

	Yes		Yes
Smoked in the past		Drink alcohol	
Currently smoke		Recreational drug use	

Medications*

Name	Dose	Purpose

**Please include over the counter medications, eye drops, vitamins, contraceptives, and herbal supplements.*

I verify that the information contained on this page is current and without changes. Signature required yearly.

Patient Signature Date