DOCTOR PAVANO & Associates

PATIENT HISTORY QUESTIONNAIRE

TODAY'S DATE ----------

Last Name _____ First _____ Mi ____ Male ___ Female ___ Birth date _____
Address _____ City _____ State _____ Zip _____
Telephone, Home ( ) _____ Work ( ) _____ Ext. _____
Employer's Name _____ Occupation _____
Social Security # _____-_____-_____ Referred by _____
Health and Vision Insurance _____ Your Physician _____

PATIENT HISTORY

What is your primary reason for today's visit? _____

Last Eye Exam _____ Last Eye Doctor _____

Do you *currently* have any problems in the following areas? If "Yes", please explain...

In relation to *your* eyes:	YES	NO	EXPLANATION OF PROBLEM...
Glaucoma, cataract, retinal disease, etc.			
Loss of vision			
Blurred vision			
Floating spots			
Flashing lights			
Double vision			
Headaches			
Dryness			
Sandy, gritty, scratchy feeling			
Itching, burning			
Mucous discharge			
Redness			
Foreign body sensation			
Excess tearing / watering			
Glare / light sensitivity			
Eye pain or soreness			
Infection of eye lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			

Have you ever had your pupils dilated? _____ No _____ Yes When _____ Complications? _____
Are you taking any medication? _____ No _____ Yes Please List _____
Are you allergic to any medication? _____ No _____ Yes Please List _____
Have you ever had an eye infection, disease, injury or surgery? _____ No _____ Yes Please List _____
Do you have trouble with night vision? _____ No _____ Yes Do you work on a computer? _____ No _____ Yes How long ? _____
What sports and hobbies do you enjoy? _____
We are affiliated with TLC (Laser Vision Centers), are you interested in laser vision correction? _____ No _____ Yes

CONTACT LENS HISTORY

Have you ever worn contact lenses? _____ No _____ Yes
Do you presently wear contact lenses? _____ No _____ Yes What type? ___ soft ___ gas perm. ___ conventional ___ disposable
Are you interested in being fit for contact lenses? _____ No _____ Yes
What lens care system do you use? _____ Heat _____ Chemical, Brand used _____
Have you ever had a reaction to any lens cleaning system? _____ No _____ Yes, Describe _____
How old are your contact lenses? R _____ L _____ Fit by: _____

Please turn over and continue...

SIGNATURE _____

REVIEW OF SYSTEMS

Do *you* currently have any general health problems? If yes, please explain…

	YES	NO	EXPLANATION OF PROBLEM
GENERAL / CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (Heart, vessels, high or low blood pressure, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (Cholesterolemia, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

Code Review of Systems (for internal use only) 1 Problem pertinent 2-9 Extended 10-14 Complete

FAMILY HISTORY

Does anyone in *your family* have any general health problems? m = mother f = father s = sibling gp= grandparent

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Age-related Macular degeneration			
early Cataract			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid Disease			
Other			

SOCIAL HISTORY

Education (high school, vocational school, college degree): _____

Marital Status (married, divorced, single, widowed): _____ No. of children _____

Do you drive? ( ) YES ( ) NO

Do you drink alcohol? ( ) YES ( ) NO If YES: Occasional 1 per day 2-3 per day 4+ per day

Do you smoke? ( ) YES ( ) NO If YES: Occasional ½ pack per day 1 pack per day 1+ pack per day

Do you use recreational drugs? ( ) YES ( ) NO If YES: Are you interested in getting help to quit?

Have you ever had a blood transfusion? ( ) YES ( ) NO

Do you have Hepatitis? ( ) YES ( ) NO Are you HIV+? ( ) YES ( ) NO

Code Past, Family and Social History: (for internal use only)
New Pertinent (1-2 Areas reviewed) Complete (3 Areas reviewed)
Established Pertinent (1 Area reviewed) Complete (2-3 Areas reviewed)

Please have insurance card(s) available for photocopying.

Reviewed by : _____
(internal use only)