Dr. Jeffery Shiau Optometrist
Health History Questionnaire

Welcome to our office! Please completely fill out this questionnaire so that we may provide you with the best possible care. Thanks!

What is the main reason for your visit to our office today?_____

Who referred you?/How did you hear about us?_____

Name:_____ Birth date:_____ SSN:_____ Gender: M/F Today's date:_____

Ethnicity:_____ Preferred language:_____ Height(Ft/inches):_____ Weight:_____

Address:_____

Telephone: (Home)_____ (Cell)_____ (Work)_____ Email:_____

Primary Care/Medical Doctor:_____ Last Physical/Checkup:_____

Eye Doctor:_____ Last Eye Exam:_____ Last Dilation:_____

Preferred Pharmacy:_____

Occupation/Job:_____ Any job-related vision needs:_____

Glasses/Contact Lenses History

Do you currently wear glasses?____ How old?_____ Frequency: Full-time/Part-time Type: Distance only/Reading only/Computer

Do you currently wear contacts?____ What brand?_____ Frequency: Full-time/Part-time Type: Hard/Soft

Are you happy with your current contacts?____ Why?_____

Are you interested in discussing your laser refractive surgery options?_____

Computer Usage

Do you use a computer? At home?_____ Hours/Day:_____ At work?_____ Hours/Day:_____

Circle any of the following that you experience while using a computer:

Blurred vision Tired eyes Dry eyes Double vision Headaches Red eyes Other:_____

Do you own computer glasses?____ Are you interested in glasses specially designed for computer work?_____

Sports and Leisure Activities

What sports do you play?_____

What recreational activities do you enjoy?_____

What hobbies do you have?_____

Do you wear any special glasses, eye protection, or contact lenses for your sports and other activities?_____

Eye and Vision Problems Circle any that apply.

Blurry Vision (with/without glasses/contacts)	Loss of Vision	Abrasion	Eye Allergy/Itchy Eyes
Double Vision (with/without glasses/contacts)	Eye Turn (In/Out)	Loss of Field of Vision	Floaters/Flashes
Foreign Body Sensation	Headaches/Migraines	Lid Lumps	Eye Pain (In/Outside Eye)
Red Eye	Trauma/Burn (Eye/Lids)		

Other:_____

Eye History Circle any that apply.

Amblyopia (Lazy Eye)	Self	Family:_____	Macular Degeneration	Self	Family:_____
Blindness	Self	Family:_____	Retinal Detachment	Self	Family:_____
Cataracts	Self	Family:_____	Strabismus (Eye Turn)	Self	Family:_____
Color Deficiency	Self	Family:_____	Eye/Lid Injury	Self	Family:_____
Glaucoma	Self	Family:_____	Surgery	Self	Family:_____

Other:_____

Medical History Circle any that apply.

AIDS/HIV Positive	Self		Heart	Self	Family:_____
Allergies	Self	Family:_____	Hypertension	Self	Family:_____
Arthritis	Self	Family:_____	Migraines	Self	Family:_____
Cancer	Self	Family:_____	Multiple Sclerosis	Self	Family:_____
High Cholesterol	Self	Family:_____	Respiratory Disorder	Self	Family:_____
Diabetes	Self	Family:_____	Stroke	Self	Family:_____
Head Trauma	Self	Family:_____	Thyroid Disorder	Self	Family:_____

Other:_____

Are you pregnant or nursing?_____

Surgical History

Please list any surgeries (Body) you have undergone and the year performed:_____

Please list any surgeries (Eye) you have undergone and the year performed:_____

Medications (Prescription, Over-The-Counter, Herbal, Etc.)

Do you take any ocular medications? Please list:_____

Do you take any systemic medications? Please list:_____

_____

Do you have any allergies to any medications and what were the side effects?_____

_____

Social History We keep all information strictly confidential.

Alcohol Use?____ Type:_____ Drinks/week:____ Tobacco Use?____ Type:_____ Cigarettes/week:____ Years smoked:_____

Narcotic Use?_____ Type:_____ Sexually Transmitted Infection?____ Type:_____ Blood Transfusion? Yes/No

Other:_____

Survey

Did you have trouble finding our office? If yes, why?_____

Did you have trouble finding parking? If yes, why?_____

How many miles did you travel to get to our office?_____

Which of these are most important to you in a pair of glasses? Stylish, Functional, Affordable, Unique, Comfortable, Durable, Light