ST. LOUIS EYE INSTITUTE

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PATIENT HEALTH QUESTIONNAIRE

Name: ______________________________ DOB: ____/____/____

1) Briefly, what is the eye issue that brings you to this office?

____

2) Do you have any ocular diseases or disorders? ☐ YES ☐ NO

☐ Glaucoma ☐ Cataracts ☐ Retinal Detachment ☐ Macular Degeneration
☐ Near Sighted ☐ Far Sighted ☐ Lazy Eye ☐ Other ______________________________

3) Have you ever had any eye surgeries? If yes, please list. ☐ YES ☐ NO

____

4) Have you noticed any changes in your vision? ☐ YES ☐ NO

If so, please describe which eye, severity, frequency, etc. ______________________________

____

5) Do you have any symptoms of Dry Eye? ☐ YES ☐ NO

☐ Redness ☐ Burning ☐ Itching ☐ Feeling of sand or grit in eyes
☐ Discomfort ☐ Watering ☐ Tired eyes ☐ Fluctuation in vision
How often do these symptoms occur? ☐ Almost never ☐ Rarely ☐ Sometimes ☐ Frequently

6) Do you take eye medications regularly? Please list frequency below. ☐ YES ☐ NO

__________ __________ __________ __________
__________ __________ __________ __________

7) Do you wear any aids to correct your vision? ☐ YES ☐ NO

☐ Glasses ☐ Readers ☐ Contact Lenses: ☐ Hard Lens ☐ Soft Lens ☐ RGP ☐ Other
If yes, for how long have you worn them? ______________________________

8) Have there been any changes in your general health in the last year? ☐ YES ☐ NO

9) Do you have any of the following health issues? ☐ YES ☐ NO

☐ Arthritis ☐ Rheumatoid Arthritis ☐ Hepatitis ☐ Liver Problems ☐ Thyroid Problems
☐ Immune Disorder (including AIDS, HIV, ARC) ☐ Lupus
☐ Hypertension ☐ Heart Disease ☐ Heart Failure
☐ Cancer Type: ______________________________ Date(s) Treated: ______________________________
☐ Diabetes: ☐ Controlled by diet ☐ Controlled by medicine ☐ Uncontrolled
☐ Other conditions (please list): ______________________________

10) Have you been hospitalized or had surgeries in the last ten years? ☐ YES ☐ NO

__________ __________ __________ __________
__________ __________ __________ __________

11) Do you take medications regularly? Please list dosages below. ☐ YES ☐ NO

__________ __________ __________ __________
__________ __________ __________ __________

12) Do you have any medical allergies? Please list below. ☐ YES ☐ NO

__________ __________ __________ __________
__________ __________ __________ __________

13) What is your: Height ______________ Weight ______________

14) Do you use tobacco products? ☐ **YES** ☐ **NO**
How much per day/week? ______________ Length of use: ______________

15) Do you use alcohol products? ☐ **YES** ☐ **NO**
How much per day/week? ______________ Length of use: ______________

16) Do you have a family history of…
☐ Glaucoma ☐ Retinal Detachment ☐ Macular Degeneration ☐ Cataracts
☐ Diabetes ☐ Hypertension

______________________________ ______________
Patient/Representative Signature Date