Dr. Wynn N. Tran
Integrative Optometry & Vision Rehab/Therapy

DATE:___/___/____

PATIENT HISTORY QUESTIONNAIRE

PATIENT INFORMATION:
LAST NAME _____ FIRST NAME:_____ MI:_____
BIRTHDATE ____/____/____ AGE_____ GENDER: _____ EMAIL:_____
CELL PHONE: ( )_____HOME: ( )_____OTHER: ( )_____
ADDRESS: _____ CITY:_____ ZIP:_____
OCCUPATION:_____ EMPLOYER or SCHOOL:_____
HOBBIES (SPORTS): _____
WHO REFERRED YOU? _____
EMERGENCY CONTACT NAME:_____ RELATIONSHIP:_____
PHONE: ( )_____ EMAIL:_____

WHAT ARE THE REASONS FOR TODAY'S VISIT (check all that apply)?

❑ Annual eye exam
❑ Distance blur
❑ Near/Reading blur
❑ Double vision
❑ Problems with computer use
❑ Brain, head injury other neurological problem
❑ Lost or broken glasses
❑ Not effective glasses
❑ Never worn glasses
❑ Learning difficulties
❑ Dizziness
❑ Red eyes
❑ Itchy eyes
❑ Unusually sensitive to light
❑ Eye pain/discomfort
❑ Vertigo
❑ Other: _____

Please further describe:
_____
_____

What are your main goals?
_____
_____

MEDICAL & EYE HISTORY

DO YOU OR ANY RELATIVES (parents, siblings, children, grandparents, aunt, uncle) HAVE ANY OF THE FOLLOWING? (check and indicate family member(s) who have the condition)

	Self:	Other family:			
❑ Diabetes	❑	❑_____	❑ Eye Disease or Injury	❑	❑_____
❑ High Blood Pressure	❑	❑_____	❑ Eye Surgery	❑	❑_____
❑ Arthritis	❑	❑_____	❑ Glaucoma	❑	❑_____
❑ Thyroid problems	❑	❑_____	❑ Cataracts	❑	❑_____
❑ Lung Disease	❑	❑_____	❑ Macular Degeneration	❑	❑_____
❑ Heart Disease	❑	❑_____	❑ Retinal Degeneration	❑	❑_____
❑ Gastrointestinal	❑	❑_____	❑ Crossed/Lazy Eye	❑	❑_____
❑ Ears/nose/throat	❑	❑_____	❑ Excessive blinking	❑	❑_____
❑ Immune	❑	❑_____	❑ Psychiatric	❑	❑_____
❑ Headaches/Migraines	❑	❑_____			
❑ Other:	❑	❑_____			

List any MEDICATIONS you are now taking: _____
_____
_____

List any ALLERGIES you have: _____

Date of LAST EYE EXAM: _____ Have you had your eyes dilated before? ❑ no ❑ yes when?_____
Age of present glasses _____yrs
If contact lens wearer, age of CL's_____yrs Type: ❑ Soft ❑ RGP/Hard ❑ Color ❑ Monovision ❑ Bifocal
Method of Wear: ❑ Daily wear ❑ Overnight wear Replacement schedule: ❑ 2 weeks ❑ 1 month ❑ Other:_____

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Have you had any OPERATIONS: ❑ Y ❑ N When? What kind? _____
_____

Name of FAMILY DOCTOR: _____Date of last visit: _____

Name & specialty of OTHER PROVIDERS/THERAPISTS involved in your care. Circle any providers you would like today's exam results to be faxed to:
_____
_____
_____

Women: Are you pregnant or nursing? ❑ Y ❑ N

Do you use cigarettes? ❑ Y ❑ N How much? _____ Plans to quit? ❑ Y ❑ N Drink Alcohol? ❑ Y ❑ N
Do you use other substances? ❑ Y ❑ N _____