

Davis Duehr Dean Patient Questionnaire

Primary Physician: _____

Referred by: _____

Age: _____

Personal Past Ocular History

- | | |
|---|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Inflammation (uveitis) |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Amblyopia (lazy eye) |
| <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Retinal Detachment |

Review of Systems

Check **Yes** or **No**

Yes No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Ears, nose, throat: cold sores / fever blisters |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular: |
| | | Heart Attack |
| | | High Blood Pressure |
| | | High Cholesterol |
| | | Slow / fast pulse / heart failure |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory: |
| | | emphysema / bronchitis / asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal: cancer / ulcers / colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Genitourinary: kidney cancer / stones / prostate |
| <input type="checkbox"/> | <input type="checkbox"/> | Musculoskeletal: arthritis / weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin Disorder: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurological: numbness / stroke / MS |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrine: diabetes / hypo/hyperthyroid |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergic / Immunologic: |
| | | Allergies / Immuno Compromised / HIV+ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer: _____ |

Social History

Occupation: _____

Do you drive? _____

Do you smoke? _____

Do you exercise regularly? _____

For physician's office use:

Date reviewed No Changes Additions as noted

Family History

(Please include siblings, parents and grandparents)

Check all that apply

- | | |
|---|--|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Amblyopia / Lazy Eye | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Other: _____ | |

Medical History

1) Drug Allergies: _____

2) General Medications: _____

3) Eye Medications: _____

4) Major illnesses or surgeries: _____

5) Eye surgeries or injuries: _____

Physician's Signature