PATIENT/DEVELOPMENT QUESTIONNAIRE

4114 West Maple Road
Bloomfield Township
248.539.4800

Name: ________________ DOB: __________ SS#: ______________ Date: __________

Name you would prefer to be called: ______________ Single Married Divorced Widowed Sex: ________

Preferred language: English ___ Spanish ___ Other: ______________

Race: African American Alaska Native American Indian Asian Caucasian Hispanic Native Hawaiian

Ethnicity: Hispanic Latino Native Hawaiian Pacific Islander Other: ______________

How would you like to be contacted?: Phone/mail/email: ______________ Email address: ______________

Address: ______________ City: ______________State: ____ Zip:__________

Home phone: ______________ Cell phone: ______________ Business/Other:______________

Responsible party: ______________ Referred by: ______________

Employer: ______________ Occupation: ______________

Business address: ______________

Spouse:______________Spouse's Employer:______________

Nearest adult relative/emergency contact name: ______________ Phone: ______________

Insurance: ______________ Name of insured: ______________ DOB: __________ ID#: ______________

Has any family member been here before? ____ Name and relationship: ______________

Primary care physician: ______________

Describe the main reason for your visit today: ______________

Have you ever been treated for this problem? ___ When was your last eye exam? ______ Name of doctor: ______________

Age of present glasses: ______ Age of present contact lenses: ______ Soft __ Rigid __ Extended wear __ Are they comfortable?: ______

Medical History:

Are you generally healthy? ______ If no please describe (include onset):

____

Please indicate any of the following that you have had (check all that apply):

eye turn	__	retinal disease	__	eye injury	__	double vision	__	eyes water	__
amblyopia/lazy eye	__	cataracts	__	eye surgery	__	eyes tired	__	rub eyes	__
drooping eyelid	__	cataract surgery	__	dry eye	__	blurred distance vision	__	blink excesivly	__
glaucoma	__	eye infections	__	eye allergies	__	blurred near vision	__	close/cover one eye	__
						eyes hurt	__	squint	__

Please describe any visual symptoms: ______________

Please list all major injuries, surgeries, and hospitalizations you have had (include the year):

____

Please list **ANY** prescription and OTC medications you are currently taking:

____

Medication allergies: ______________ Reaction: ______________ Onset:__________

Non-Medication allergies: ______________ Reaction: ______________ Onset:__________

Height: _________ Weight: _________ Are you pregnant or nursing? __________

Family History:

	Y/N	Relation		Y/N	Relation
History Unknown	____		Cancer, type __________	____	______________
Blindness	____	______________	Diabetes	____	______________
Cataract	____	______________	Heart disease	____	______________
Eye turns	____	______________	High blood pressure	____	______________
Glaucoma	____	______________	Kidney disease	____	______________
Macular degeneration	____	______________	Thyroid disease	____	______________
Retinal detachment	____	______________	Other ______________	____	______________

Social History:

Do you smoke? Never __ Former __ Current ___ When did you stop? ________ years _______ months ago. Smokeless tobacco?_____

Alcohol use : None ____ Daily ____ Social use ____ Alcohol dependence ____ Do you use any illegal drugs? ____

Do you drive? _____ Do you have any visual difficulty when driving (describe)?______________

Please continue to the next page.

Review of Systems

Cardiovascular/Vascular:	Y/N	Onset
High Blood Pressure	_____	________
Heart Prob.: _____________	_____	________
Vascular Disease	_____	________
Constitutional:		
Fever	_____	________
Weight gain/loss	_____	________
Fatigue	_____	________
Endocrine:		
Diabetes	_____	________
Thyroid	_____	________
Pituitary disorder	_____	________
Gastrointestinal:		
Acid reflux	_____	________
Diarrhea	_____	________
Constipation	_____	________
Genitourinary:		
Genital	_____	________
Kidney	_____	________
Bladder	_____	________

Ears/Nose/Mouth/Throat:	Y/N	Onset
Runny nose	_____	________
Chronic cough	_____	________
Dry throat/mouth	_____	________
Hearing loss	_____	________
Sinus disease	_____	________
Hematologic/Lymphatic:		
Anemia	_____	________
Blood disorder	_____	________
Bleeding problem	_____	________
Immune system/Infections:		
Sjogrens syndrome	_____	________
Autoimmune disease	_____	________
HIV Positive/AIDS	_____	________
Lyme disease	_____	________
Sarcoidosis	_____	________
Tuberculosis	_____	________
Lupus	_____	________
Integumentary/Skin:		
Skin rash/hives	_____	________
Dermatitis	_____	________
Dry skin	_____	________
Rosacea	_____	________

Musculoskeletal:	Y/N	Onset
Arthritis	_____	________
Muscle pain	_____	________
Skeletal disorder	_____	________
Neurological:		
Headache/Migraine	_____	________
Brain tumor	_____	________
Seizures	_____	________
Stroke	_____	________
Psychiatric:		
ADD/ADHD	_____	________
Autism spectrum	_____	________
Other (please describe)		
________________________	_____	________
________________________	_____	________
Respiratory:		
Asthma	_____	________
Emphysema	_____	________
Chronic bronchitis	_____	________
Sleep apnea	_____	________
Other: __________________	_____	________

Please fill out the section below if patient is under the age of 18.

Developmental History: Birth weight: _________ Delivered at full term? _____ If no, explain: ____________________
Complications during pregnancy? _____ If yes, explain: ____________________
Complication during or after birth? _____ If yes, please explain: ____________________
Any of the following NOT occur at expected time? sit ___ crawl ___ stand ___ walk ___ say first word ___ talk in sentences ___ put puzzles together ____
ride bicycle __ handwriting __ Does child: have balance problems __ veer right/left when walking __ run into things__ toe walk__ lean forward when walking __

School Information: School: ____________________ Grade: __________
Address: ____________________ Repeated grades: _________ Average grades: ______
Rate child's progression in the following subjects (1=below average, 2=average, 3=advanced): reading ______ spelling ______ writing ______ math ______
Please state any school difficulties: ____________________
Has there been any therapy for a learning problem? If yes, please explain: ____________________

Medical History:
Date of last physical: ______________ List any other professionals that work with your child:
1. ____________________
2. ____________________
3. ____________________
Does your child experience any of the following:

Hyperactivity	_____	Frustrates easily	_____	Not working up to potential	_____	Bumps into things	_____
Behavior problems	_____	Difficulty in reading	_____	Holds books close to eyes	_____	Poor coordination	_____

Other: ____________________

I attest that this form in complete and accurate to the best of my knowledge ____________________
Signature *Date*