# Advance Eye Care, O.D. PA

**Dr. Sarit G. Catchatoorian O.D.**

**Date_____**

## PATIENT HISTORY QUESTIONNAIRE

Last Name_____ First Name_____ Middle_____
Address_____ City_____ State_____ ZIP_____
Home Phone_____ Work Phone_____ Cell Phone_____
Occupation_____ Employer_____
Date of Birth_____ Age_____ Gender: Male or Female
Social Security # _____ Medical Insurance _____ Vision Insurance _____
Date of Last Eye Exam _____ Were you dilated? YES NO
Email _____ Referred By _____ Hobbies/Interests_____

**Insurance Information:**

Main Member/Spouse/Parent_____ DOB_____ Employer_____
Phone_____ Social Security # _____

## MEDICAL INFORMATION

DO YOU HAVE ANY PROBLEMS WITH ANY OF THESE SYMPTOMS (PLEASE CHECK)

| | | |
|---|---|---|
| ☐ Respiratory | ☐ Headaches | ☐ Muscle/Joint |
| ☐ High Blood Pressure | ☐ Gastrointestinal/Urinary | ☐ Mental |
| ☐ Diabetes | ☐ Neurological | ☐ Cancer |
| ☐ Thyroid | ☐ Blood/Lymph | ☐ Seasonal Allergies |

Please explain_____
Other health problems_____
Do you smoke? Yes/No Alcohol? Yes/No If so, how often? _____ Allergies to Med(s)_____
Past Surgery_____ When? _____ Last Physical/Visit _____
Primary Care Doctor_____ Practice Name _____
Current Medication(s) _____

## OCULAR HISTORY

| | | |
|---|---|---|
| ☐ Blurry Vision | ☐ Glaucoma | ☐ Cataracts |
| ☐ Eye Surgery | ☐ Dry Eyes | ☐ Flashes/Floaters |
| ☐ Loss of Vision | ☐ Macular Degeneration | ☐ Eye Allergies |
| ☐ Eye Injury | ☐ Retinal Detachment | ☐ Glare/Light Sensitivity |

## FAMILY HISTORY

| | RELATION | | RELATION |
|---|---|---|---|
| ☐ High Blood Pressure | _____ | ☐ Glaucoma | _____ |
| ☐ Diabetes | _____ | ☐ Blindness | _____ |
| ☐ Stroke | _____ | ☐ Macular Degeneration | _____ |
| ☐ Cataract | _____ | ☐ Retinal Detachment | _____ |

| | |
|---|---|
| Do you have more than one pair of current RX glasses? | YES NO |
| Do you wear sunglasses outside? | YES NO |
| Do you work on the computer for long periods? | YES NO |
| Do you spend a lot of time outdoors? | YES NO |
| Are there times you'd rather not wear glasses? | YES NO |
| Are you satisfied with your current contact lenses? | YES NO |
| Interested in learning about laser vision correction? | YES NO |

**DOCTOR USE ONLY**

REVIEWED BY_____ CHANGES DATE_____
REVIEWED BY_____ CHANGES DATE_____