Valley Health Clinic, Inc.
8609 Sudley Road, Suite 105
Manassas, VA 20110
703-393-8883

Health History Questionnaire

The answers on this form will help your care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, decline to answer it. If you can't remember a specific detail, please approximate the answer. Add any notes you feel are important. NOTE: ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

Patient Name: _________________________________ **Date:**____/____/______

Date of Birth: ____/_____/______

Allergies:

Allergy	Reaction

Medications:

Medication	Dose Strength	Frequency Taken

Past Medical History: (please check all that apply)

☐ ADD/ADHD
☐ Asthma
☐ COPD
☐ Depression
☐ Eczema, Hives, skin conditions
☐ HIV/STI
☐ Hospital Admission other than birth
☐ Liver Disease
☐ Sarcoidosis
☐ Anxiety Disorder
☐ Bladder or Kidney Problems
☐ Cancer
☐ Diabetes
☐ Fibromyalgia
☐ Heart Disease
☐ Hypertension
☐ Multiple Sclerosis
☐ Seizure/Epilepsy
☐ Arthritis
☐ Blood Diseases
☐ Coronary Artery Disease
☐ Ear or Hearing Problems
☐ GERD/Reflux
☐ High Cholesterol
☐ Hypothyroidism
☐ Osteoporosis
☐ Serious Illness or injuries
☐ Stroke

Past Medical Surgeries: ____

Date of Last Eye Exam: ____/____/______

Do you have currently any problems with your eyes?

☐ Loss of vision ☐ Redness ☐ Eye pain or soreness ☐ Blurred vision
☐ Sandy or Gritty feeling ☐ Fluctuating vision ☐ Itching ☐ Tired Eyes
☐ Distorted vision (halos) ☐ Burning ☐ Drooping eyelid ☐ Loss of peripheral vision
☐ Foreign body sensation ☐ Floaters ☐ Double vision ☐ Excess tearing/watering
☐ Flashes ☐ Dryness ☐ Glare/light sensitivity ☐ Mucus Discharge ☐ Other

Do you wear glasses? Yes ☐ No ☐ **Do you wear contact lenses**? Yes ☐ No ☐
Describe your contact lens history: Comfort______________Do you sleep/nap in contacts? Yes ☐ No ☐
Disposal schedule:___________________ Brand of material: ________________________

Past Ocular History

☐ Amblyopia ☐ Myopia ☐ Ocular Trauma ☐ Iritis ☐ Glaucoma ☐ Strabismus (eye turned)
☐ Diabetic Retinopathy ☐ Macular Degeneration ☐ Retinal Detachment ☐ Optic Nerve disorder
☐ Cataract ☐ LASIK ☐ PRK ☐RK ☐ Cornea Cross-Linking

Family Medical and Ocular History

Relation (check all conditions that apply)	**Alive**	**Age**	**Acquired Blindness**	**Age related Macular Degeneration**	**Alzheimer's Disease**	**Anxiety Disorder**	**Asthma**	**Cataract**	**Color Blindness**	**Coronary Arteriosclerosis**	**Depressive Disorder**	**Diabetes**	**Disorder of thyroid**	**Glaucoma**	**Hypercholesterolemia**	**Hypertensive Disorder**	**Keratoconus**	**Kidney Disease**	**Malignant Neoplastic**	**Myocardial Infarction**	**Retinal Detachment**	**Seizure Disorder**	**Stroke**
Grandmother Maternal	☐Yes ☐No																						
Grandfather Maternal	☐Yes ☐No																						
Grandmother Paternal	☐Yes ☐No																						
Grandfather Paternal	☐Yes ☐No																						
Father	☐Yes ☐No																						
Mother	☐Yes ☐No																						
Siblings	☐Yes ☐No																						
Other	☐Yes ☐No																						

Social History

What is your Occupation? ______________________ **What is your education level?** ________________
FOR WOMEN TO ANSWER: Are you pregnant ☐Yes☐No **Are you breast feeding**? ☐Yes☐No
Do you smoke? ☐Yes☐No ☐Former but quit **If yes, How much?** ______________
Do you drink alcohol? ☐Yes☐No **If yes, How much**? _________________
Do you have difficulty driving at night? ☐Yes☐No **Do you have difficulty watching TV?** ☐Yes☐No
Do you know your dominant eye? ☐Yes Right or Left ☐Don't Know
Do you live alone or with others? ☐Alone☐With others