



Previously treated or diagnosed with Glaucoma?  Yes  No

Previously treated or diagnosed with Cataracts?  Yes  No

Previously treated or diagnosed with other eye conditions:  Yes  No

If yes, what? \_\_\_\_\_  
\_\_\_\_\_

11. Do you use artificial tears?  Yes  No

If yes, how often?  1-4x's daily  5-8x's daily  few times a week  occasionally

Do you use Visine, Clear Eyes or "get the red out" drops?  Yes  No

If yes, how often?  daily  few times weekly  few times monthly  occasionally

Do you use other eye drops?  Yes  No

If yes, indicate eye, type & frequency \_\_\_\_\_

### Family Ocular History

12. List any eye diseases that run in your family: \_\_\_\_\_  
\_\_\_\_\_

### General Medical History

13. List any medications you are allergic to: \_\_\_\_\_

14. Do you smoke?  yes  no

If so, how much per day: \_\_\_\_\_

15. Have you previously undergone any cosmetic procedure(s):  yes  no

If yes, what procedures: \_\_\_\_\_

If yes, did you heal as expected? \_\_\_\_\_

16. List other surgeries you have had, with dates: \_\_\_\_\_  
\_\_\_\_\_

17. Do you feel that you didn't heal from a medical procedure as expected?  yes  no

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Do you feel like doctors ignored your medical concerns (not eye related)?  yes  no

If yes, please explain:

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19. Do you feel like the quality of care provided by your previous eye doctor has been unsatisfactory?  yes  no

If yes, please explain:

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20. Do you feel like a doctor didn't deliver quality results for your medical care?  yes  no

If yes, please explain:

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21. Current medications/Recreational Drugs:

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22. Current vitamins/supplements:

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23. If female,  
are you or might you be pregnant?  yes  no  
are you trying to become pregnant?  yes  no  
are you breastfeeding?  yes  no

24. Please check any of the following that has been suspected or treated, currently or in the past:

**Adrenal Disorders**

- Addison's Disease
- Cushing's Syndrome

**Arthritis, Bone or Joint**

- Gout
- Psoriatic Arthritis
- Reiter's Syndrome
- Rheumatoid Arthritis
- Spondylitis

**Blood/Artery or Cardiac**

- Anemia - Aplastic
- Anemia - Hemolytic
- Anemia - Pernicious
- Anemia - Sickle-cell
- Erythropoietic Porphyria
- Vitamin B12 Deficiency
- Waldenstrom's Macroglobulinemia

**Connective Tissue Disorders**

- Dermatomyositis
- Lupus
- Connective Tissue Disease
- Raynaud's
- Relapsing Polychondritis

**Gastro-Intestine Conditions**

- Celiac Disease
- Crohn's Disease
- Inflammatory Bowel Disease
- Ulcerative Colitis

**Infectious Diseases**

- Lyme Disease
- Syphilis

**Infectious Diseases cont.**

- Tuberculosis
- Other \_\_\_\_\_

**Immune Disorders**

- AIDS
- HIV

**Inflammatory Conditions**

- Ankylosing Spondylitis
- Pancreatitis
- Sarcoidosis

**Liver Conditions**

- Elevated Bilirubin
- Gilbert Syndrome
- Hepatitis

**Neurologic or Muscular**

- Fibromyalgia
- Inflammatory Neuropathy
- Leprosy
- Multiple Sclerosis
- Myasthenia Gravis
- Myositis
- Polymyalgia Rheumatica

**Ophthalmic Conditions**

- Cogan's Syndrome
- Glaucoma
- Ophthalmic Herpes Zoster
- Scleritis
- Scleromalacia Perforans
- Sjogren's Syndrome
- Uveitis

**Skin Conditions**

- Atopy

**Skin Conditions cont.**

- Atopic Dermatitis
- Erythema Nodosum
- Erythema Multiforme
- Granuloma Annulare
- Porphyria
- Psoriasis
- Scleroderma

**Systemic, Vascular or Organ**

- Behcet's Disease
- Berger's Disease
- Blood Pressure (high/low)
- Cancer Type \_\_\_\_\_
- Churg-Strauss Syndrome
- Diabetes
- Gallbladder Conditions
- Giant-Cell Arteritis
- Goodpasture Syndrome
- Heart Disease
- Kawasaki's Disease
- Kidney Disease
- Liver Disease
- Periarteritis Nodosa
- Takayasu Disease
- Vasculitis
- Wegener's Granulomatosis

**Thyroid Conditions**

- Grave's Disease
- Hashimoto's Thyroiditis
- Hyper or Hypo Thyroidism

**Viral Disease**

- Herpes Zoster  
Where: \_\_\_\_\_
- Herpes Simplex  
Where: \_\_\_\_\_
- Shingles

25. List any other immune or auto-immune conditions: \_\_\_\_\_

26. List any other medical conditions not previously noted: \_\_\_\_\_

27. Have you ever been declined any surgery of any kind from another doctor?  yes  no

If yes, please explain: \_\_\_\_\_

### Family Medical History

28. Do you have family history Auto-Immune diseases?  yes  no

If yes, what? \_\_\_\_\_

### Other Info

29. If you were referred to us, who referred you?  Doctor  Boxer Wachler Patient  Other

Where can we send a thank you letter and gift to your referral?

Address \_\_\_\_\_  
Street City State Zip Code

Phone # (\_\_\_\_\_) \_\_\_\_\_

30. Primary Eye Doctor Name \_\_\_\_\_

(check one)  OPTOMETRIST  OPHTHALMOLOGIST

Address \_\_\_\_\_  
Street City State Zip Code

Phone # (\_\_\_\_\_) \_\_\_\_\_

31. Primary Medical Doctor Name \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Phone # (\_\_\_\_\_) \_\_\_\_\_

32. Other doctors/specialists providing medical care: (list name/phone number)

\_\_\_\_\_

35. May we send a letter to your doctors to update them on your visit(s) with us?  yes  no

May we send your medical records to your doctors if they request them?  yes  no

Sign to authorize us to release records \_\_\_\_\_

Date \_\_\_\_\_

# Questionnaire

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Place an X on the scale toward the direction that best rates your response to the questions below

How often do you use "get the red out" eye drops? .....  
Never Rarely Weekly Daily

How often do you use artificial tears? .....  
Never Rarely Weekly Daily

How often are your eyes red when you wake up? .....  
Never Rarely Weekly Daily

Do you worry about the appearance of your eyes? .....  
Never Rarely Weekly Daily

How unhappy are you with the appearance of your eyes? .....  
Not at All Slightly Moderately Extremely

How much distress do you experience from the appearance of your eyes? .....  
None Slight Moderate Extreme

How much time do you spend each day thinking about the appearance of your eyes? .....  
None less than 1 hour 4-8 hours 8+ hours

How often does the appearance of your eyes affect your ability to work? .....  
Never Occasionally All the time

How often does the appearance of your eyes affect your outlook on life? .....  
Never Occasionally All the time

How else has the appearance of your eyes affected you: .....  
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