Last Name: _____ **First:** _____ **Age:**_____ **Sex:** _____
Date:_____ **Referred By:**_____ **Occupation:**_____

PATIENT HISTORY QUESTIONNAIRE

All information is strictly confidential and will be released only with written permission.

Current Medications: **(Please list any medications including eye drops/ supplements/vitamins that you take.)**
☐ **None**

Name of Medications Eye Drops/Supplement/Vitamin	**Dose** (How much per day)	**Name of Doctor Prescribing**

Drug Allergies with reactions:

_____
_____
_____
_____
_____

Social History:

Tobacco ☐ No ☐ Yes (including smokeless tobacco)
How many per day:_____ How long: _____
Have you used tobacco in the past? ☐ No ☐ Yes Approx. date started _____ Date stopped:_____
Alcohol ☐ No ☐ Yes
Number per week: _____ Wine _____Beer _____ Hard Liquor _____
Recreational Drugs ☐ No ☐Yes
Ever used intravenous drugs ☐ No ☐ Yes Date last used:_____
Marital Status: Married _____ Divorced _____ Single _____ Widowed _____ Student _____
Children: ☐ No ☐ Yes
Number _____
Hobbies/ Special Interests: _____

Reason for Visit: (Please explain the problems that bring you to our office today.)

Surgical History:

Eye Surgeries/Laser Treatments ☐ None

Type of Operation: Date: Complications:

All Other Surgeries ☐ None

Type of Operation: Date: Complications:

Lab Testing/Studies: Date Location Phone# (*if known*)

Blood Work:

X-Ray:

CAT Scan:

MRI:

Other:

Physician(s): Please give the name, address and phone numbers of any doctors you are currently seeing. If more space is needed, please use back of questionnaire.

Past Medical History: (Mark any of the conditions that you currently have or have a history of and in the space provided please describe and indicate how long you have had this problem)

☐ None

Diabetes: ☐ Y ☐ N (☐ insulin / ☐ no insulin) Year Diagnosed _____ Last A1C _____

Allergies:	☐ Y ☐ N _____	**Osteoporosis:**	☐ Y ☐ N _____
Alzheimer's/Dementia:	☐ Y ☐ N _____	**Night Sweats:**	☐ Y ☐ N _____
Anemia/Bleeding Problems:	☐ Y ☐ N _____	**Heart Problems/CVD :**	☐ Y ☐ N _____
Arthritis (Osteo, Rheumatoid):	☐ Y ☐ N _____	**Hepatitis A, B, C:**	☐ Y ☐ N _____
Asthma/ Bronchitis:	☐ Y ☐ N _____	**High Blood Pressure:**	☐ Y ☐ N _____
Blindness:	☐ Y ☐ N _____	**High Cholesterol:**	☐ Y ☐ N _____
Blood Transfusion:	☐ Y ☐ N _____	**HIV /AIDS :**	☐ Y ☐ N _____
Cancer:	☐ Y ☐ N _____	**Lupus:**	☐ Y ☐ N _____
Depression:	☐ Y ☐ N _____	**Migraine:**	☐ Y ☐ N _____
Emphysema/ COPD:	☐ Y ☐ N _____	**Sickle Cell Anemia:**	☐ Y ☐ N _____
Epilepsy/Seizures:	☐ Y ☐ N _____	**Stroke :**	☐ Y ☐ N _____
Glaucoma:	☐ Y ☐ N _____	**Thyroid Disease:**	☐ Y ☐ N _____
Kidney/Urinary Problems:	☐ Y ☐ N _____	**Tuberculosis(TB):**	☐ Y ☐ N _____
Ulcer/Stomach Problems:	☐ Y ☐ N _____	**Other:**	☐ Y ☐ N _____

Family Medical History: **(In the space provided please indicate relationship. For example "maternal grandmother", "paternal grandfather" or "brother" ect.)**

Anemia:	☐ Y ☐ N _____	**Heart Problems/Disease:**	☐ Y ☐ N _____
Arthritis:	☐ Y ☐ N _____	**Hepatitis:**	☐ Y ☐ N _____
Bleeding Problems:	☐ Y ☐ N _____	**High Blood Pressure:**	☐ Y ☐ N _____
Blindness:	☐ Y ☐ N _____	**Macular Degeneration:**	☐ Y ☐ N _____
Cancer:	☐ Y ☐ N _____	**Migraine/ Headaches:**	☐ Y ☐ N _____
Cataract:	☐ Y ☐ N _____	**Retinal Detachment:**	☐ Y ☐ N _____
Corneal Problems:	☐ Y ☐ N _____	**Sickle Cell:**	☐ Y ☐ N _____
Diabetes:	☐ Y ☐ N _____	**Stroke:**	☐ Y ☐ N _____
Emphysema:	☐ Y ☐ N _____	**Thyroid Disease:**	☐ Y ☐ N _____
Epilepsy/Seizures:	☐ Y ☐ N _____	**Tuberculosis (TB):**	☐ Y ☐ N _____
Glaucoma:	☐ Y ☐ N _____	**Other :**	☐ Y ☐ N _____

REVIEW OF SYSTEMS
CHECK those that apply or CHECK - NONE

Health in general: ☐ Chills, ☐ Fatigue, ☐ Fever, ☐ Weight Gain, ☐ Weight Loss,
☐ Other _____ ☐ **NONE**

Skin: ☐ Excessive dryness, ☐ itching, ☐ skin lesion, ☐ rash (*eczema, psoriasis, rosacea*)
☐ Other _____ ☐ **NONE**

Ears, Nose, Mouth, Throat: ☐ Sinus pain, ☐ ear discharge, ☐ ear pain, ☐ hearing loss, ☐ tinnitus (*ringing/buzzing/swoosh*), ☐ nasal congestion, ☐ nosebleeds, ☐ rhino rhea (*runny nose*), ☐ hoarseness, ☐ sore throat, ☐ Other _____ ☐ **NONE**

Cardiovascular: ☐ Chest pain, ☐ claudication(*leg pain/cramping*), ☐ dyspnea on exertion(*shortness of breath with effort*), ☐ leg swelling, ☐ orthopnea(*shortness of breath while laying down*), ☐ palpitations, ☐ Other _____ ☐ **NONE**

Respiratory: ☐ Cough, ☐ hemoptysis (*coughing up blood*), ☐ shortness of breath, ☐ sputum, ☐ production, ☐ wheezing, ☐ sleep apnea (cpap Y/N), ☐ Other _____ ☐ **NONE**

Gastrointestinal: ☐ Abdominal pain, ☐ belching, ☐ blood in stool, ☐ constipation, ☐ diarrhea, ☐ heartburn, ☐ hemorrhoids, ☐ nausea, ☐ trouble swallowing, ☐ vomiting,
☐ Other _____ ☐ **NONE**

Genitourinary: ☐ Irregular menses, ☐ bladder incontinence, ☐ polyuria(*frequent urination*), ☐ dysuria (*painful urination*), ☐ Other _____ ☐ **NONE**

Muscle, Joint and Bone: ☐ Back pain, ☐ falls joint pain, ☐ myalgias (*muscle pain*), ☐ neck pain, ☐ Other _____ ☐ **NONE**

Neurological: ☐ Dizziness, ☐ focal weakness, ☐ headache, ☐ loss of consciousness, ☐ seizures, ☐ speech change, ☐ tingling, ☐ tremor, ☐ Other _____ ☐ **NONE**

Psychiatric: ☐ Depression, ☐ hallucinations, ☐ insomnia, ☐ memory loss, ☐ nervous/anxious, ☐ Other _____ ☐ **NONE**

Allergic/ Immunology: ☐ Environmental allergies, ☐ Other _____ ☐ **NONE**

Blood and Lymph: ☐ Easy bruise/ bleed, ☐ lymph node swelling,
☐ Other _____ ☐ **NONE**

Glands and Endocrine: ☐ Hot flashes, ☐ polydipsia, (frequent thirst), ☐ sweating,
☐ Other _____ ☐ **NONE**