

PATIENT HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____

Primary Care Physician: _____

Were you referred? Yes No If Yes, by whom? _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: (including eye drops, vitamins, supplements etc...) _____

Allergies to medication or food: _____

OCULAR HISTORY: (please check yes or no and explain all that apply)

	Yes	No	
Blurred, Distorted or Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of vision or Fluctuation of vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Floater/ Flashes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain/ Soreness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Review of Systems: (please check yes or no and explain all that apply)

Constitutional Systems:	Yes	No	
Fever, weight loss, other	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Nose, Mouth, Throat:			
Hearing or sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular System:			
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease/heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart surgery/Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Systems: (lungs, breathing)			
Asthma, emphysema, TB	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal: (stomach, intestine)			
Jaundice, hepatitis, ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hernia, reflux, GI bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary: (genital, kidney, bladder)			
Kidney disease, pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integumentary: (skin and/or breast)			
Skin disease, skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculo-skeletal			
Degenerative arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus/ Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

PLEASE TURN OVER – CONTINUED ON OTHER SIDE

Neurological

Fainting, dizziness

Migraines, seizures

Stroke, paralysis

Psychiatric

Depression

Schizophrenia/ Other

Hematologic / Lymphatic

Anemia, sickle cell

Bleeding disorder

Leukemia/ Other

Allergic/ Immunologic

Seasonal allergies

Immune disorder

Hay fever/ other

Endocrine

Diabetes, thyroid

Hormone replacement

HIV/ AIDS:

List past surgeries:

Date: _____

Type: _____

Date: _____

Type: _____

Describe any other problems, illnesses, or conditions that were not previously mentioned:

FAMILY HISTORY: Do you have a family history of:

Diabetes **Yes** **No**

Glaucoma

Macular degeneration

Retinal detachment

Other eye disease

Social History: **Yes** **No**

Do you drink alcohol?

Do you smoke?

Family member: _____

Please explain: _____

Initial

Date