

Patient History Questionnaire

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

PhoneNumber _____ CellPhone _____ EmergencyPhoneNumber _____

E-Mail Address _____

Social Security Number _____

Primary Physician: Name _____

Address _____

Phone _____

Referring Physician: Name _____

Address _____

Phone _____

Review of Systems

Please check **YES** or **NO**, in bold boxes, if yes, specify in small box and explain.

	YES	NO	EXPLANATION OF PROBLEM
Constitutional Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Loss.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
 Eyes	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Blurry vision.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic infection of eyes or lids.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted vision.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess tearing/watering.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluctuating visual activity.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign body sensation.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare/light sensitivity.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of side vision.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of vision.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous discharge.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Occasional tearing.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain or soreness.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or gritty feeling.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sty, Chalazion.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired eyes.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you having any difficulty?			
Reading small print.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reading in general.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Recognizing people when close..... _____
 Seeing to go up and down steps or curbs... _____
 Driving in bright light..... _____

Eyes Continued	YES	NO	EXPLANATION OF PROBLEM
Driving in the dark.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reading street/traffic signs.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Doing fine handiwork.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writing (checks, cards, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Playing games (bingo, cards, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Playing sports (golf, tennis).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Doing hobbies.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Watching TV/Movies.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you satisfied with your present vision?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Eyes History	YES	NO	When Diagnosed	Treatment	FamilyMember (Relationship)
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
“Lazy”/Crossed Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Retina Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Night Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Eyelid	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Current Eye Medications
 Eye Problem(s) _____ Name of Medication(s) _____

Past Eye Surgery
 Date(s) _____ Operation(s) _____

	YES	NO	EXPLANATION OF PROBLEM
Ears, Nose, Mouth, Throat.....	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Hearing problems.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus congestion.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny nose.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post-nasal drip.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry throat/mouth.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Congestive heart failure.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attacks.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irregular/fast heartbeat.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pain/angina.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery (describe)			_____

Respiratory (Lungs/Breathing).....

Asthma.....

Emphysema.....

Tuberculosis.....

Lung Cancer.....

Sarcoidosis.....

Other.....

Surgery

(If no, proceed to next topic)

Gastrointestinal **YES** **NO**

(Stomach/Intestines)

Jaundice/Hepatitis.....

Ulcers/Bleeding.....

Hiatal Hernia.....

Cancer.....

Other.....

Surgery

EXPLANATION OF PROBLEM

(If no, proceed to next topic)

Genitourinary

(Genitals/Kidney/Bladder)

Kidney disease.....

Prostate cancer.....

Cervical/Uterine/Ovarian/
Breast Cancer.....

Pregnant now?.....

Surgery

(If no, proceed to next topic)

Integumentary

(Skin and/or Breast)

Skin disease.....

Skin cancer.....

Breast Disease.....

Breast Cancer.....

Other.....

Surgery

(If no, proceed to next topic)

Musculo-Skeletal

Degenerative arthritis.....

Rheumatoid arthritis.....

Lupus.....

Cancer.....

Other.....

Surgery

(If no, proceed to next topic)

Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>
Migraines.....	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures/Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/Paralysis.....	<input type="checkbox"/>	<input type="checkbox"/>
Benign tumor.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's.....	<input type="checkbox"/>	<input type="checkbox"/>
Other.....	<input type="checkbox"/>	<input type="checkbox"/>
Surgery		

(If no, proceed to next topic)

Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Depression.....	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia.....	<input type="checkbox"/>	<input type="checkbox"/>
Other.....	<input type="checkbox"/>	<input type="checkbox"/>

(If no, proceed to next topic)

	YES	NO
Hematologic/Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
Swelling.....	<input type="checkbox"/>	<input type="checkbox"/>
Lymph nodes.....	<input type="checkbox"/>	<input type="checkbox"/>
Surgery		

EXPLANATION OF PROBLEM

(If no, proceed to next topic)

Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>
Head allergy symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>
Immune problems.....	<input type="checkbox"/>	<input type="checkbox"/>
General allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Other.....	<input type="checkbox"/>	<input type="checkbox"/>
Surgery		

(If no, proceed to next topic)

Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer-pancreas/adrenal glands...	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
Other.....	<input type="checkbox"/>	<input type="checkbox"/>
Surgery		

(If no, proceed to next topic)

Current Medications including Eye Medications

Allergies to Medicines

List all allergies to medicines

Past History

Describe any other problems, illnesses, surgeries, or medicines that were not described in the above questions.

Family History

Describe any major illnesses or hereditary problems including eye diseases of parents, grandparents or brothers/sisters.

Social History

Drugs
Alcohol
Smoking
Recent Voyages
Other

Yes

No

EXPLANATION

Date _____

Patient Signature _____

Date _____

Physician Signature _____