

PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____

Review Of Systems: Please indicate YES or NO. If yes, please give explanation. Be sure to list any surgeries you have had. **PLEASE COMPLETE BOTH SIDES OF THIS QUESTIONNAIRE.**

	YES	NO	
<u>Constitutional System</u>			
Fever	___	___	_____
Weight Loss	___	___	_____
Other	___	___	_____
<u>Eyes</u>			
Chronic Infection	___	___	_____
Double Vision	___	___	_____
Dryness	___	___	_____
Itching	___	___	_____
Loss of Vision	___	___	_____
Mucous Discharge	___	___	_____
Pain or Redness	___	___	_____
Stye or Chalazion	___	___	_____
Visual Acuity Fluctuation	___	___	_____
Other	___	___	_____
<u>Ear, Nose, Mouth, Throat</u>			
Sinus Congestion	___	___	_____
Hearing Problems	___	___	_____
Chronic Cough	___	___	_____
Dry Throat/Mouth	___	___	_____
Other	___	___	_____
<u>Cardiovascular</u>			
Congestive Heart Failure	___	___	_____
Heart Attack	___	___	_____
Blood Pressure Problem	___	___	_____
Chest Pain/Angina	___	___	_____
Other	___	___	_____
<u>Respiratory</u>			
Asthma	___	___	_____
Emphysema	___	___	_____
Tuberculosis	___	___	_____
Lung Cancer	___	___	_____
Sarcoidosis	___	___	_____
Other	___	___	_____
<u>Gastrointestinal (Stomach/Intestines)</u>			
Jaundice/Hepatitis	___	___	_____
Ulcers/Bleeding	___	___	_____
Hiatal Hernia	___	___	_____
Cancer	___	___	_____
Other	___	___	_____
<u>Genitourinary (Kidney, Bladder)</u>			
Kidney Disease	___	___	_____
Prostrate Cancer	___	___	_____
Cervical, Ovarian Cancer	___	___	_____
Other	___	___	_____
<u>Integumentary (Skin/Breast)</u>			
Skin Disease/Cancer	___	___	_____
Breast Disease/Cancer	___	___	_____
Other	___	___	_____

	YES	NO	
Musculoskeletal			
Degenerative Arthritis	___	___	_____
Rheumatoid Arthritis	___	___	_____
Lupus	___	___	_____
Cancer	___	___	_____
Other	___	___	_____
Neurological			
Fainting/Dizziness	___	___	_____
Migraines	___	___	_____
Seizures/Epilepsy	___	___	_____
Stroke/Paralysis	___	___	_____
Alzheimer's	___	___	_____
Benign Tumor	___	___	_____
Other	___	___	_____
Psychiatric			
Hematologic/Lymphatic			
Anemia	___	___	_____
Sickle Cell Disease	___	___	_____
Leukemia	___	___	_____
Swelling	___	___	_____
Allergic/Immunologic			
Seasonal Allergies	___	___	_____
Hay Fever	___	___	_____
HIV +	___	___	_____
Other	___	___	_____
Endocrine			
Diabetes	___	___	_____
Thyroid Problems	___	___	_____
Other	___	___	_____

Family History: Do any of your blood relatives have any of the following:

	Yes	No	Relationship	Yes	No	Relationship	
Blindness	___	___	_____	Cancer	___	___	_____
Cataract	___	___	_____	Arthritis	___	___	_____
Glaucoma	___	___	_____	Diabetes	___	___	_____
Retina Problems	___	___	_____	Heart	___	___	_____
Retina Problems	___	___	_____	Thyroid	___	___	_____
Eye Muscle	___	___	_____	Blood	___	___	_____
Macular Degen.	___	___	_____	Pressure	___	___	_____
Other	___	___	_____	Other	___	___	_____

Are you allergic to any medications? _____
 If yes, please list those medications: _____

List ALL Medications you are currently using: _____

Are you allergic to Latex? ___ YES ___ NO

Social History:

Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced
 Do you Smoke? ___ YES ___ NO If yes, occasional ½ pack/day 1 pack/day 1+ pack/day
 Do you drink Alcohol? ___ YES ___ NO if yes, Occasional, 1 per day 2-3 per/day 4+ per day

Date _____ Patient's Signature _____
 (Parent or Guardian, if minor)