

Patient History Questionnaire

Occupation

Hobbies

Current & Past Medical Problems: (including eyes)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Current Medication:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Allergies to Medicines

List all allergies to medications

Environmental Allergies?

Past Surgical History (All):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Family/Social History:

YES NO

YES NO

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Blindness from what _____ | <input type="checkbox"/> Other, Please |
| <input type="checkbox"/> Cataracts | |

explain _____

- Cancer if yes what type _____

Past, Family, Social History

Are you: Single Married Divorced Widow

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

Describe any major illnesses or hereditary problems of parents, grandparents or brothers/sisters _____

Social History

- | | YES | NO |
|---------|--------------------------|--------------------------|
| Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> |
| Smoking | <input type="checkbox"/> | <input type="checkbox"/> |

EXPLANATION

Review of Systems

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

	YES	NO	EXPLANATION OF PROBLEM
General 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"/>	_____
Night Sweats	<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 vision	<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"/>	_____
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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seeing to go up and down steps or curbs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Driving in bright light	<input type="checkbox"/>	<input type="checkbox"/>	_____
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.)
- Playing games (bingo, cards, etc.)
- Playing sports (golf, tennis)
- Doing hobbies
- Watching TV/Movies

	YES	NO	EXPLANATION OF PROBLEM
<u>Ears, Nose, Mouth, Throat</u>	<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"/>	_____
Dry throat/mouth.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seasonal Allergy	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Cardiovascular</u>	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Irregular/fast heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of breath while awake.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Respiratory (Lungs/Breathing)</u>	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coughing.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seasonal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Gastrointestinal (Stomach/Intestines)</u>	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Jaundice/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tarry Stools	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood in Stools	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Genitourinary</u>	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Frequent Urinating	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficult Urinating	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain with Urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Integumentary</u>	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Mole changes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rash	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itch	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Musculo-Skeletal</u>	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Neurological</u>	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Dizzy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spinning Sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty Working	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Hematological/Lymphatic</u>	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)

Weakness _____
Fatigue _____
Anemia _____
Swollen Lymph Nodes _____

Endocrine (If no, proceed to next topic)
Diabetes _____
Cancer-pancreas/adrenal glands _____
Thyroid problems _____
Thyroid cancer _____
Hormone Replacement Therapy _____

Date _____

Patient Signature _____

Date _____

Physician Signature _____