Patient History Questionnaire

Occupational_____

Hobbies_____

Current & Past Medical Problems: (including eyes)

1._____ **5.** _____

2._____ **6.**_____

3._____ **7.**_____

4._____ **8.**_____

Current Medication:

1._____ **5.** _____

2._____ **6.**_____

3._____ **7.**_____

4._____ **8.**_____

5._____ **10.**_____

Allergies to Medicines

List all allergies to medications

_____

Environmental Allergies?_____

Past Surgical History (All):

1._____ **4.** _____

2._____ **5.**_____

3._____ **6.**_____

Family/Social History:

Y	N		Y	N		Y	N	
☐	☐	Diabetes	☐	☐	Heart Disease	☐	☐	Drugs
☐	☐	Glaucoma	☐	☐	High Blood Pressure	☐	☐	Alcohol __ a day
☐	☐	Blindness from what_____	☐	☐	Other, Please explain____	☐	☐	Smoking __ a day
☐	☐	Cataracts.....						
☐	☐	Cancer if yes what type_____			_____			

Social History

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 _____

_____

Review of Systems ☐ if negative please check box (s)

Please **circle** any symptoms, add any other symptoms and if you have any comments.

General Symptoms ☐

Fever, night sweats, weight loss, other/comments_____

Eyes: ☐

blurry vision, burning, chronic infection eyes/lids, distorted vision, double vision, dryness, excessive watering/tearing, fluctuating visual activity, foreign body sensation, glare/light sensitivity, itching, loss of vision, pain or soreness, redness, sandy/gritty feeling, other/comments _____

_____

Are you having any difficulty? ☐

Reading small print, reading in general, recognizing people when close, seeing to go up/down steps/curbs, driving in bright light, driving in the dark, reading street/traffic signs, doing fine handiwork, writing (checks, cards, etc.), playing games (bingo, cards, etc.), playing sports (golf, tennis), doing hobbies, watching TV/Movies other/comments_____

_____

Ears, Nose, Mouth, Throat: ☐

Hearing problems, sinus congestion, runny nose, dry throat/mouth, seasonal allergy, other/comments_____

_____

Cardiovascular ☐

Irregular/fast heartbeat, chest pain, shortness of breath while awake, other/comments_____

Respiratory (Lungs/Breathing) ☐

Shortness of breath, coughing, seasonal problems, other/comments_____

Gastrointestinal (Stomach/Intestines)

Jaundice/Hepatitis, abdominal pain, tarry stools, blood in stools, other/comments _____

Genitourinary ☐

Frequent Urinating, difficult urinating, pain with urination, other/comments_____

Integument ☐

Mole changes (itchy), rash, skin cancer, other skin changes/comments_____

Musculo-Skeletal ☐

Joint Pain, back pain, muscle pain, other/comment_____

Neurological ☐

Dizzy, spinning sensation, seizures, memory loss, tremors, difficulty working, other/comments_____

_____

Hematological/Lymphatic ☐

Weakness, fatigue, anemia, swollen lymph nodes, other/comments_____

Endocrine ☐

Diabetes, cancer-pancreas/adrenal glands, thyroid problems, thyroid cancer, hormone replacement therapy, other/comments

_____

Date _____ Patient Signature _____

Date _____ Physician Signature _____

Darrell Kohli MD Jaylene Iverson OD