

Patient Medical History Questionnaire

Name _____ SS# _____ D.O.B. ___/___/_____
 Primary Care Doctor _____ Phone # _____

REVIEW OF SYSTEMS			
	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
CONSTITUTION		GENITOURINARY	ENDOCRINE
Fever		Kidney Disease	Diabetes
Weight Loss		Prostrate Cancer	Cancer pancreas/adrenal glands
CARDIOVASCULAR		Cervical/Uterine	Thyroid Problems
Congestive Heart Failure		Ovarian/Breast Cancer	Hormone Replacement Therapy
Heart murmur		Pregnant Now?	HEMATOLOGIC/LYMPHATIC
Heart Attacks		MUSCULO-SKELETAL	Anemia
Irregular/fast Heartbeat		Degenerative Arthritis	Sickle Cell Disease
Blood Pressure		Rheumatoid Arthritis	Bleeding Disorder
Chest Pain/angina		Lupus	Leukemia
ENT/MOUTH		INTEGUMENTARY	AIDS
Hearing Problems		Skin Disease / Cancer	Swelling
Runny Nose		Breast Disease / Cancer	Lymph Nodes
Sinus Congestion		NEUROLOGICAL	ALLERGIC/ IMMUNOLOGIC
Chronic Cough		Dizziness / Fainting	Head Allergy Symptoms
Dry Throat/Mouth		Convulsions/Seizures/Epilepsy	Seasonal Allergies
RESPIRATORY		Stroke / Paralysis	Hay Fever Symptoms
Asthma		Benign Tumor	Immune Problems
Emphysema		Migraines / Headaches	General Allergies
Tuberculosis		Alzheimer's	OTHER
Sarcoidosis		PSYCHIATRIC	
GASTROINTESTINAL		Depression	
Jaundice/Hepatitis		Schizophrenia	CANCER
Ulcers/Bleeding			
Hiatal Hernia			

ALLERGIES – Circle all that apply

NKDA	Codeine	Fluorescein	Narcotics	Thimerosal
ASA	Dairy Products	Latex	Penicillin	Xalatan
Bees	Dogs	Mites	Pollen	Yeast
Beta Blockers	Erythromycin	Mold	Sulfa	Iodine
Cats	Fluorescein	Mydriatics	Tetracycline	Other:

SOCIAL HISTORY – Circle all that apply

Drugs	Alcohol	Smoking	Occupational Hazards	Recent Travel	Other:
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SURGICAL HISTORY – Please list

Date (mm/yyyy)	Procedure	Surgeon - Hospital

PATIENT EYE HISTORY

PAST / PRESENT OCULAR HISTORY			FAMILY OCULAR HISTORY Persons Related by blood only; Mother, Father, Maternal/Paternal Grandparent, Brother, Sister, Aunt, Uncle		
	<input checked="" type="checkbox"/>	Date Diagnosed		<input checked="" type="checkbox"/>	Relationship to patient
Glaucoma			Glaucoma		
Cataracts			Cataracts		
ARM D			ARM D		
Eye Injury			Eye Injury		
Retinal Disease			Retinal Disease		
Other Ocular Disease			Other Ocular Disease		
Blindness			Blindness		
Strabismus/Eye Muscle Problems			Strabismus		
Amblyopia			Amblyopia		
Diabetes			Diabetes		
Dry Eye			Dry Eye		
Refractive Error			Cancer		
Night Blindness			Heart Disease		
Other			Other		

PAST OCULAR SURGERY – PLEASE LIST		
Date (mm/yyyy)	Procedure	Surgeon

INJURY TO THE EYE

Date: _____ Describe: _____

Please check all that apply.

				Yes/No
Blurred Vision	Itching	Do You have difficulty seeing up close?		
Burning	Loss of Side Vision	Do you have difficulty seeing at a distance?		
Chronic Infection of Eyes or lids	Loss of Vision	Difficult driving at night?		
Distorted Vision	Mucous Discharge			
Double Vision	Occasional Tearing	Do you wear prescription glasses?		
Dryness	Pain or Soreness	Do you wear reading glasses?		
Excess Tearing/Watering	Redness	Do you wear Contact Lenses?		
Floaters or Flashes	Sandy or Gritty feeling	Other Vision Problems:		
Foreign Body Sensation	Sty, Chalazion			
Glare/Light Sensitivity	Tired Eyes			