PATIENT HISTORY QUESTIONNAIRE

To all patients:

The following questionnaire is intended to help us better evaluate and treat your medical problems. We appreciate you filling it out in its entirety; should you have any questions about what information to include, please do not hesitate to ask the office staff. Thank you.

Name:_____ **Date of Birth:**_____ **Date:** _____

1. What is the medical problem that you believe needs to be addressed? _____
_____
2. Do you wear glasses? Y ☐ N ☐
3. Do you wear contacts? Y ☐ N ☐
4. Do you need or want a contact lens prescription? Y ☐ N ☐
5. Are you interested in learning more about Laser Vision Correction (LASIK)? Y ☐ N ☐

REVIEW OF SYMPTOMS:

Do you presently have any problems in the following areas? Check all that apply and provide explanation.

General Symptoms
Fever ☐
Wight Loss ☐
Other ☐
Eyes
Loss of Vision ☐
Blurred Vision ☐
Distorted Vision ☐ (halos)
Loss of side vision ☐
Double vision ☐
Dryness ☐
Discharge ☐
Redness ☐
Sandy/gritty feeling ☐
Itching/burning ☐
Foreign body sensation ☐
Excess tearing ☐
Glare/Light sensitivity ☐
Eye pain or soreness ☐
Chronic infection ☐
Sties, chalazion ☐
Fluctuating vision ☐
Tired eyes ☐
Hematologic
Blood ☐
Swelling ☐

Allergic/Immunologic
Head Allergy ☐
Seasonal/Hay fever ☐
Ears, Nose, Mouth
Sinus Congestion ☐
Runny Nose ☐
Post nasal drip ☐
Chronic cough ☐
Dry throat/mouth ☐
Cardiovascular
Heart/blood vessels ☐
Respiratory
Lungs/breathing ☐
Chronic bronchitis ☐
Gastrointestinal
Stomach/intestines ☐
Musculoskeletal
Muscle/joint ☐
Integumentary
Skin and or breast ☐
Neurological ☐
Psychiatric ☐
Endocrine
Thyroid ☐
Other ☐_____

EXPLANATION OF SYMPTOMS:

_____

_____

_____

PATIENT HISTORY QUESTIONNAIRE (continued)

Name:_____ **Date of Birth:**_____ **Date:** _____

PAST MEDICAL HISTORY/CURRENT ILLNESSES (CHECK ALL THAT APPLY):

Anemia ☐
Arthritis ☐
Asthma ☐
Bladder Disease ☐
Bleeding Tendencies ☐
Bronchitis ☐
Cancer ☐ What Type:
Cataracts ☐
Chicken Pox ☐
Dementia(Memory Problems) ☐
Diabetes ☐
Emphysema ☐
Gallbladder Problems ☐
Glaucoma ☐
Heart Disease ☐
Hearing Loss ☐
Hepatitis ☐ A__B__C__
High Blood Pressure ☐
HIV ☐
Mental Illness ☐
Influenza ☐
Jaundice ☐
Kidney Failure ☐
Kidney Stones ☐
Measles ☐
Hyperlipidemia (high cholesterol or triglycerides) ☐
Mumps ☐
Pregnant ☐
Reflux ☐
Seizures ☐
Skin Lesions/Rash ☐
Sickle Cell Disease ☐
Stroke ☐
Tuberculosis ☐
Thyroid Disease ☐
Sexually Transmitted Disease☐
Other ☐_____
_____
_____

Operations/Hospitalizations:_____
_____

Medications/Dietary/Herbal Supplements:
_____
_____

List Allergies or Reactions to Medications:
_____

PATIENT HABITS:

	Present	Past	Amount
Tobacco (cigarettes, chewing, pipes, cigars)	Y ☐ N ☐	Y ☐ N ☐	_____
Alcohol	Y ☐ N ☐	Y ☐ N ☐	_____
Exercise	Y ☐ N ☐	Y ☐ N ☐	_____
Illicit Drugs	Y ☐ N ☐	Y ☐ N ☐	_____

Type of Drugs_____

FAMILY HISTORY: (check those that a family member has had)

Alzheimer's Disease ☐
ARMD ☐
Asthma ☐
Arthritis ☐
Thyroid Disease ☐
Cancer ☐
Diabetes ☐
Epilepsy ☐
Glaucoma ☐
Other: ☐
Heart Problems ☐
High Blood Pressure ☐
Kidney Disease ☐
Retinal Disease ☐