PATIENT HISTORY QUESTIONNAIRE/REVIEW OF SYSTEMS

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 do not hesitate to ask the office staff. Thank you.

Name ________________________ **Date** ________________

Date of Birth ____________________ **Age** ________________

1. What is the medical problem you need addressed today? ____________________
2. Do you wear contacts? ____________________
3. Do you need or want a contact lens prescription? ____________________

PAST MEDICAL HISTORY/CURRENT ILLNESSES:

______Anemia
______Asthma
______Arthritis
______Bladder Disease
______Bleeding Tendencies
______Bronchitis
______Cancer: What Type______________________
______Cataracts
______Chicken Pox
______Dementia(Memory Problems)
______Diabetes
______Emphysema
______Gallbladder Problems
______Reflux
______Glaucoma
______Hearing Loss
______Heart Disease
______Hepatitis: __A__B__C
______High Blood Pressure
______Influenza
______Hyperlipidemia (high cholesterol or triglycerides)
______Jaundice
______Kidney Failure
______Kidney Stones
______Measles
______Mental Illness
______Mumps
______Pregnant
______ Sexually Transmitted Disease: What Type__________
______Seizures
______Skin Lesions/Rash
______Sickle Cell Disease
______Stroke
______Thyroid Disease
______Tuberculosis
______Other:

OPERATIONS/HOSPITALIZATIONS: ____________________

MEDICATIONS/: ____________________

DIETARY/HERBAL SUPPLEMENTS: ____________________

LIST ALLERGIES OR REACTIONS TO MEDICATIONS: ____________________

PATIENT HISTORY QUESTIONNAIRE

Name:_________________________________Date of Birth:_______________________

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

Mother's age (or age at death) _____ Alive? Yes___ No _____
Mother's Medical Problems: ____

____

Father's age (or age at death) _____ Alive? Yes___ No _____
Father's Medical Problems: ____

____

_____Alzheimer's Disease
_____Cancer
_____Glaucoma
_____Thyroid Disease
_____Other:

______Asthma
______Diabetes
______Heart Problems
______High Blood Pressure

_______Arthritis
_______Epilepsy
_______Kidney Disease

PATIENTS HABITS:

	Present	Past	Amount
Tobacco (cigarettes, chewing, pipes, cigars)	___Y/N	__Y/N	_______
Alcohol	___Y/N	__Y/N	_______
Illicit Drugs	___Y/N	__Y/N	_______
Type of Drugs_______________________________________			
Exercise	___Y/N	__Y/N	_______

PATIENT HISTORY QUESTIONNAIRE

Name:________________________________ Date of Birth:____________________

REVIEW OF SYSTEMS:
Do you presently have any problems in the following areas? If "Yes", provide information.

Symptoms	Yes	No	Explanation of problems	Symptoms	Yes	No	Explanation of problems
General Symptoms	Yes	No		**Allergic/Immunologic**	Yes	No	
Fever	☐	☐	___________	Head Allergy	☐	☐	___________
Weight Loss	☐	☐	___________	Seasonal/hay Fever	☐	☐	___________
Other	☐	☐	___________	**Ears, Nose, Mouth, Throat**			
Eyes				Sinus congestion	☐	☐	___________
Loss of vision	☐	☐	___________	Runny nose	☐	☐	___________
Blurred vision	☐	☐	___________	Post nasal drip	☐	☐	___________
Distorted vision (halos)	☐	☐	___________	Chronic cough	☐	☐	___________
Loss of side vision	☐	☐	___________	Dry throat/mouth	☐	☐	___________
Double vision	☐	☐	___________	**Cardiovascular**			
Dryness	☐	☐	___________	Heart/blood vessels	☐	☐	___________
Discharge	☐	☐	___________	**Respiratory**			
Redness	☐	☐	___________	Lungs/breathing	☐	☐	___________
Sandy or gritty feeling	☐	☐	___________	Chronic bronchitis	☐	☐	___________
Itching/burning	☐	☐	___________	**Gastrointestinal**			
Foreign body sensation	☐	☐	___________	Stomach/intestines	☐	☐	___________
Excess tearing	☐	☐	___________	**Genitourinary**			
Glare/Light Sensitivity	☐	☐	___________	Genitals/kinder/bladder	☐	☐	___________
Eye pain or soreness	☐	☐	___________	**Musculoskeletal**			
Chronic infection	☐	☐	___________	Muscle/joint	☐	☐	___________
Sties, chalazion	☐	☐	___________	**Integumentary**			
Fluctuating vision	☐	☐	___________	Skin and or breast	☐	☐	___________
Tired eyes	☐	☐	___________	**Neurological**	☐	☐	___________
Hematologic				**Psychiatric**	☐	☐	___________
Blood	☐	☐	___________	**Endocrine**			
Swelling	☐	☐	___________	Thryoid	☐	☐	___________
Other	☐	☐	___________				