PATIENT HISTORY QUESTIONNAIRE

Name:_____

Date:_____

REVIEW OF SYSTEMS: PLEASE CHECK THE ONES THAT APPLY TO YOU.

EYES	YES	NO
Blurry Vision	☐	☐
Burning	☐	☐
Chronic Infection of Eyes or Lids	☐	☐
Distorted Vision / Halos	☐	☐
Do you currently wear glasses?	☐	☐
Do you currently wear contact lenses?	☐	☐
Do you work at a computer?	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Eye Muscle Problems	☐	☐
Excess Tearing / Watering	☐	☐
Foreign Body Sensation	☐	☐
Flashes / Floaters / Spots	☐	☐
Glare / Light Sensitivity	☐	☐
Glaucoma	☐	☐
Itching	☐	☐
Loss of Vision	☐	☐
Loss of Side vision	☐	☐
Mucus Discharge from Eyes	☐	☐
Night Blindness	☐	☐
Pain or Soreness	☐	☐
Past Eye Surgery	☐	☐
Redness	☐	☐
Retina Problems	☐	☐
Sandy or Gritty Feeling	☐	☐
Sty, Chalazion	☐	☐
Tired Eyes	☐	☐

CONSTITUTIONAL SYMPTOMS	YES	NO
Fever	☐	☐
Weight Gain	☐	☐
Weight Loss	☐	☐

EARS, NOSE, MOUTH, THROAT	YES	NO
Allergies / Hay Fever	☐	☐
Chronic Cough	☐	☐
Dry Throat / Mouth	☐	☐
Hearing Problems	☐	☐
Post-Nasal Drip / Runny Nose	☐	☐
Sinus Congestion	☐	☐

ENDOCRINE	YES	NO
Diabetes	☐	☐
Cancer-Pancreas / Adrenal Glands	☐	☐
Hormone Replacement Therapy	☐	☐
Thyroid Problems / Cancer	☐	☐

GASTROINTESTINAL	YES	NO
Cervical / Uterine / Ovarian Cancer	☐	☐
Diarrhea / Constipation	☐	☐
Kidney Disease	☐	☐
Prostate Cancer	☐	☐

INTEGUMENTARY	YES	NO
Breast Cancer	☐	☐
Skin Disease or Cancer	☐	☐

LYMPHATIC / HEMATOLOGIC	YES	NO
Anemia	☐	☐
Bleeding Disorder	☐	☐
Blood Cancer	☐	☐
Lymph Nodes	☐	☐
Sickle Cell Disease	☐	☐

MUSCULO-SKELETAL	YES	NO
Cancer	☐	☐
Degenerative Arthritis	☐	☐
Fibromalgia	☐	☐
Joint Pain	☐	☐
Lupus	☐	☐
Muscle Pain	☐	☐
Rheumatoid Arthritis	☐	☐

NEUROLOGICAL	YES	NO
Alzheimer's	☐	☐
Cancer	☐	☐
Convulsions	☐	☐
Seizures	☐	☐
Epilepsy	☐	☐
Fainting	☐	☐
Headaches	☐	☐
Migraines	☐	☐

PSYCHIATRIC	YES	NO
Depression	☐	☐
Schizophrenia	☐	☐

RESPIRATORY	YES	NO
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Lung Cancer	☐	☐
Sarcoidosis	☐	☐
Tuberculosis	☐	☐

VASCULAR / CARDIOVASCULAR	YES	NO
Pacemaker	☐	☐
Congestive Heart Failure	☐	☐
Heart Pain	☐	☐
Angina	☐	☐
Heart Attacks	☐	☐
High Blood Pressure	☐	☐
Irregular Heartbeat	☐	☐
Vascular Disease	☐	☐

Dr. Sign._____ Date_____ Dr. Sign._____ Date_____

Dr. Sign._____ Date_____ Dr. Sign._____ Date_____

SOCIAL HISTORY

(This information is kept strictly confidential.)
Or you may check the following box below.

☐ *I would prefer to discuss my Social History information directly with my doctor.*

	YES	NO
Do you drive?	☐	☐
Do you have difficulty when driving?	☐	☐

Explain:_____

_____

_____

	YES	NO
Do you use tobacco products?	☐	☐

Type / Amount / How long _____

_____

Do you drink alcohol? ☐ ☐

_____

_____

Do you use illegal drugs? ☐ ☐

_____

Have you ever been exposed to or infected with:

☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

FAMILY / SELF HISTORY:

Check if you are someone in your family has had any of the following:

☐ Blindness_____

☐ Cataracts_____

☐ Diabetes_____

☐ Glaucoma_____

☐ High Blood Pressure_____

☐ Macular Degeneration_____

☐ Retinal Detachment_____

☐ Stroke_____

LIST OF CURRENT MEDICATIONS:

_____

_____

_____

_____

_____

_____

_____

NAME OF PRIMARY CARE DR:

_____