

Patient History Questionnaire

Name: _____ Age: _____ Career: _____ Date: _____

Referring MD: _____ Primary Care Physician: _____

Past History

A. Circle all illnesses below which patient has presently or has had in the past:

| | | | | |
|-----------|--------|---------------------|---------------|--------------|
| Diabetes | AIDS | High Blood Pressure | Heart Attack | Tuberculosis |
| Arthritis | HIV | Emphysema | Heart Failure | Lupus |
| Cancer | Stroke | Thyroid Disorder | Leukemia | Lymphoma |
| | | | | Asthma |

List any other major illnesses: _____

B. List All Medications Currently Using:

| | MEDICINE | DOSE | TIMES PER DAY | | | |
|-----|----------|-------|---------------|---|---|---|
| 1. | _____ | _____ | 1 | 2 | 3 | 4 |
| 2. | _____ | _____ | 1 | 2 | 3 | 4 |
| 3. | _____ | _____ | 1 | 2 | 3 | 4 |
| 4. | _____ | _____ | 1 | 2 | 3 | 4 |
| 5. | _____ | _____ | 1 | 2 | 3 | 4 |
| 6. | _____ | _____ | 1 | 2 | 3 | 4 |
| 7. | _____ | _____ | 1 | 2 | 3 | 4 |
| 8. | _____ | _____ | 1 | 2 | 3 | 4 |
| 9. | _____ | _____ | 1 | 2 | 3 | 4 |
| 10. | _____ | _____ | 1 | 2 | 3 | 4 |

C. Drug Allergies:

CIRCLE ANY DRUGS BELOW TO WHICH PATIENT IS ALLERGIC:

| | |
|------------|--------------|
| PENICILLIN | TETRACYCLINE |
| ASPIRIN | CIPRO |
| IODINE | SULFA |

OTHER ALLERGIES: _____

D. Circle Any of the Surgical Procedures Patient has had and List Any Additional Surgeries:

| | |
|---------------------|--|
| Tonsillectomy | Hysterectomy (Removal of Uterus/Ovaries) |
| Prostate Surgery | Heart Bypass |
| Gallbladder Removal | Lumbar Disectomy (Back Surgery) |

| | | |
|----------------------|-------|------|
| Cataract Surgery: | Right | Left |
| Retinal Reattachment | Right | Left |

Other

Surgeries: _____

E. Review of Recent Health Systems:

| | Yes | No | | | | Yes | No | Right | Left |
|------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Constitutional Symptoms: | | | | | | | | | |
| Fever/Chills | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | |
| Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | |
| Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | |
| Night Sweats | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | |
| 2. Eyes: | | | | | | | | | |
| Loss of Vision | <input type="checkbox"/> | <input type="checkbox"/> | Right | Left | Floaters | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of Vision (<5 minutes) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Flashes of Light | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blurred Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Side Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Distorted Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye Pain/Soreness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (straight lines are crooked) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| Glare/Light Sensitivity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Burning | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

(Review of Recent Health Systems, Continued)

| | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 3. Ear, Nose, Throat, Mouth | | | 4. GI (Stomach/Intestines) | | |
| Sinus Congestion | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> |
| Sore Throat | <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | <input type="checkbox"/> |
| Runny Nose | <input type="checkbox"/> | <input type="checkbox"/> | Blood w/ Bowel Movement | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold Sores Lip/Mouth | <input type="checkbox"/> | <input type="checkbox"/> | Cramping, Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Cardiovascular (Heart, Blood Vessels) | | | 6. Skin | | |
| Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | Tick Bites | <input type="checkbox"/> | <input type="checkbox"/> |
| Rapid Heart Beat | <input type="checkbox"/> | <input type="checkbox"/> | Rashes | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Skips Beat | <input type="checkbox"/> | <input type="checkbox"/> | Sores | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Respiratory (Breathing, Lungs) | | | 8. Neurological | | |
| Cough | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Balance | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty Breathing | <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma Attacks | <input type="checkbox"/> | <input type="checkbox"/> | Weakness Arm/Leg/Face | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Allergy | | | Nausea/Vomiting | <input type="checkbox"/> | <input type="checkbox"/> |
| Seasonal Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Numbness Arm/Leg/Face | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. GU (Kidney, Bladder, Genitals) | | | 11. Hematological (Blood, Lymph) | | |
| Blood in Urine | <input type="checkbox"/> | <input type="checkbox"/> | Anemia (Low Blood Count) | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning w/ Urination | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal White Blood Cells | <input type="checkbox"/> | <input type="checkbox"/> |
| Sores on Genitals | <input type="checkbox"/> | <input type="checkbox"/> | Swollen Lymph Nodes | <input type="checkbox"/> | <input type="checkbox"/> |

F. Social History

| | | | |
|--------------------|--------------------------|--------------------------|--|
| Married | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do You Smoke | <input type="checkbox"/> | <input type="checkbox"/> | (If Yes, How Long _____, & How Many Packs a Day _____) |
| Do You Drink | <input type="checkbox"/> | <input type="checkbox"/> | (If Yes, How Much _____) |
| Drugs for Pleasure | <input type="checkbox"/> | <input type="checkbox"/> | (If Yes, What _____, & How _____) |

G. Family History

| | | | |
|----------------------|--------------------------|--------------------------|-------------------------|
| Blindness | <input type="checkbox"/> | <input type="checkbox"/> | Relationship to Patient |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Retinal Detachment | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | _____ |