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
1. Constitutional Symptoms:		
Fever/Chills	☐	☐
Weight Loss	☐	☐
Fatigue	☐	☐
Night Sweats	☐	☐

2. Eyes:	Yes	No	Right	Left		Yes	No	Right	Left
Loss of Vision	☐	☐	☐	☐	Floaters	☐	☐	☐	☐
Loss of Vision (<5 minutes)	☐	☐	☐	☐	Flashes of Light	☐	☐	☐	☐
Blurred Vision	☐	☐	☐	☐	Loss of Side Vision	☐	☐	☐	☐
Distorted Vision	☐	☐	☐	☐	Eye Pain/Soreness	☐	☐	☐	☐
(straight lines are crooked)	☐	☐	☐	☐					
Glare/Light Sensitivity	☐	☐	☐	☐	Burning	☐	☐	☐	☐

(Review of Recent Health Systems, Continued)

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

F. Social History

Married	☐	☐	
Do You Smoke	☐	☐	(If Yes, How Long ____, & How Many Packs a Day___)
Do You Drink	☐	☐	(If Yes, How Much _____)
Drugs for Pleasure	☐	☐	(If Yes, What _____, & How _____)

G. Family History

			Relationship to Patient
Blindness	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____
Diabetes	☐	☐	_____
Cancer	☐	☐	_____
Heart Attack	☐	☐	_____
High Blood Pressure	☐	☐	_____
Tuberculosis	☐	☐	_____
Stroke	☐	☐	_____
Other	☐	☐	_____