Patient Health History Questionnaire

Name: Date of Birth: Date:

Current Height: Weight: Age: Sex: M / F

Medications:	**Please List all Medications and Supplements You Are Taking**	
Name:	**Dosage / Frequency**	**Why are you taking this?**
❍ No Medications		
1		
2		
3		
4		
5		
6		

Allergies /Sensitivities:	**Describe the reaction?**
❍ No Known Drug Allergies	
1	
2	
3	
4	

Medical Conditions:	**Please List All Past/Current Medical Conditions**	
❍ No Medical Conditions	**Date**	**How was or is this treated?**
1		
2		
3		
4		

Please Mark if you have a history of the following conditions and give a brief explanation:

☐ **Asthma**			☐ **Hepatitis A,B, or C**	☐ Cirrhosis	
☐ **Autoimmune Disease**	*Type:*		☐ **High Blood Pressure**		
☐ **Cancer**	*Type:*		☐ **High Cholesterol**		
☐ **Congestive Heart Failure**			☐ **Kidney Disease**	☐ Dialysis	
☐ **COPD**			☐ **Liver Disease**		
☐ **Coronary Bypass or Stent**	Date:		☐ **Pacemaker or Defibrillator**		
☐ **Diabetes**	*Type: 1 or 2*	*Insulin or Meds*	☐ **Pregnant or Nursing**		
☐	*Recent A1c / Blood Sugars:*	___________	☐ **Seizures**		
☐ **Emphysema / Bronchitis**			☐ **Sleep Apnea**	☐ CPAP	
☐ **Heart Attack**	*Date:*		☐ **Stroke / TIA**	*Date:*	
☐ **Heart Disease**	*Cardiologist:*		☐ **Thyroid Disease**	*Type:*	*Hypo or Hyper*

Please list ALL known Procedures /Surgeries, or use this space for Comments:

Past Ocular History	**Which Eye?**	**Date:**		**Which Eye?**	**Date:**
Cataract Surgery	L or R Both		Macular Degeneration	L or R Both	
Glaucoma	L or R Both		Diabetic Retinopathy	L or R Both	
Amblyopia	L or R Both		Retinal Detachment	L or R Both	
LASIK	L or R Both		Vitrectomy		

Procedures/Comments:

Patient Name: **Date of Birth:**

Family Medical History		
❍Unknown Family History	Yes	Relation?
Amblyopia		
Arthritis		
Diabetes		
Glaucoma		
Cancer		
Heart Disease		
Macular Degeneration		
Stroke		
Thyroid Disease		
Other:		

Social History		
	Yes	How Often per Week or Day?
Do you:		
Drink Alcohol?		
Drink Caffeine?		
Currently Smoke?		
(Are you a) Former Smoker?		
Quit Year?		
Use Recreational/Illegal Drugs?		

Do you use an Oxygen Tank? Y or N **Require use of a Wheelchair?** Y or N

Review of Systems

Mark Yes if you CURRENTLY experience these symptoms

Constitutional

Yes	
	Fatigue
	Fever
	Weight Loss/Gain
	Recent Cold/ Flu

HEENT

Yes	
	Blurred Vision
	Double vision
	Floaters
	Hearing Loss
	Tinnitus or Ringing of Ears
	Scotoma or Blind Spot
	Sinus Problems
	Sore throat
	Vertigo
	Vision changes
	Vision loss

Respiratory

Yes	
	Difficulty Breathing
	Shortness of Breath
	Wheezing

Cardiovascular

Yes	
	Chest Pressure or Discomfort
	Irregular Heartbeat
	Palpitations

Gastrointestinal

Yes	
	Abdominal Pain
	Difficulty Swallowing
	Heartburn
	Nausea / Vomiting
	Reflux

Genitourinary

Yes	
	Painful Urination
	Urgency

Metabolic

Yes	
	Heat Intolerance
	Cold Intolerance

Neurological

Yes	
	Balance Disturbance
	Dizziness
	Headache
	Numbness of Extremities

Dermatologic/Integumentary

Yes	
	Skin Lesion /Open Wound
	Rashes

Musculoskeletal

Yes	
	Neck Pain
	Back Pain
	Difficult to lie flat
	Jaw Pain
	Joint Pain
	Muscle Weakness

Psychiatric

Yes	
	Depressed Mood
	Hallucinations
	Stress

Hematologic

Yes	
	Bruises Easily
	Bleeding

Immunologic

Yes	
	Environmental Allergies
	Seasonal Allergies

Additional Health comments :