Health History Questionnaire

Name:_____ **Date of Birth:**_____ **Age:**_____

Current Height:_____ **Current Weight:**_____ **Sex (circle) : Male / Female**

CURRENT MEDICATIONS: □ **NONE**

Include ALL: Prescription, Over the Counter, Vitamins, Minerals, Herbs, Supplements, Eye drops, Eye Vitamins*

*Please, attach list if necessary.

Medication	Dose/Mg	X per day
1.		
2.		
3.		
4.		

Medication	Dose/Mg	X per day
5.		
6.		
7.		
8.		

Allergies (with reaction) to Medications: _____

(Please list)

Allergies (with reaction) to Foods, Tape, Soap, LATEX, etc._____

(Please list)

FAMILY HISTORY: Have any of your blood relatives had these diseases? ☐ **Unknown**

Yes	Condition/Disease	Relation to you?
	Macular Degeneration	
	Retinal Detachment/ Tears	
	Diabetes	
	Glaucoma	
	Other Retinal Disorders	
	Blindness	

Yes	Condition/Disease	Relation to you?
	Cancer, type:	
	Heart Disease	
	Hypertension	
	Stroke	
	Thyroid disease	
	Amblyopia/Strabismus	

Have you or a blood relative ever had a complication with anesthesia? ☐ No ☐ Yes

If Yes, describe:_____

PAST OCULAR (EYE) HISTORY: ☐ NONE

Eye Condition / Diagnosis:	Procedure / Surgeries:	Right / Left	Date

PAST HISTORY of ILLNESSES and OPERATIONS: □ NONE

(Please include condition/diagnosis with procedure/surgeries and date of condition/diagnosis commenced.)

Condition / Diagnosis:	Procedure / Surgeries:	Date / Year of Diagnosis

Other:

Do you wear? Contacts: ☐ NO ☐ YES > If so, are they Hard or Soft (circle)? How many years?_____

Do you wear? Hearing Aids: ☐ NO ☐ YES > Left / Right / Both

Do you wear? Dentures: ☐ NO ☐ YES

Patient Sticker

MEDICAL HISTORY/REVIEW OF SYSTEMS Patient's Name:_____

✓ CHECK ALL THAT APPLY CIRCLE ALL THAT CURRENTLY APPLY

Left	Right	Eyes
		Visual Changes
		Visual Field Defect
		Scotomas / Blind Spot
		Double Vision
		Glaucoma
		Cataract Surgery
		Retina Surgery
		Blurred Vision
		Loss of Vision
		Distortion/Wavy Vision
		Floaters
		Flashes
		Eye Pain
Other >		

Past	Current	Cardiovascular
		Chest Pain or Pressure
		Irregular Heartbeat
		Palpitations
		Congestive Heart Failure
		Coronary Bypass or Stent
		High Blood Pressure
		High Cholesterol
		Pacemaker or Defibrillator
Other >		

Past	Current	Respiratory
		Asthma
		Shortness of Breath
		Wheezing
		Pain with Breathing
		Emphysema/Bronchitis
		COPD/Oxygen at home? Y / N
		Sleep Apnea/Wear CPAP?
Other >		

Write Answer	Diabetes
	< Type I or Type II?
	< Year Diagnosed?
	< Oral Meds?
	< Insulin Reg/NPH?
	< Diet Controlled?
	< A1C (most current)?
	< Date of Last A1C?

Constitutional
- Fatigue
- Fever
- Weight Gain / Loss
- Recent Cold / Flu
- Other:

HEENT
- Nasal Congestion
- Ringing in Ears
- Vertigo
- Other:

Gastrointestional
- Heartburn
- Reflux
- Trouble Swallowing
- Other:

Genitourinary
- Kidney Stones / Pain
- Protein in Kidneys
- Kidney Dysfunction
- Chronic Urinary Tract Infection
- Dialysis > When_____
- Prescribed/Used Flomax?
- Other:

Neurologic/Psychiatric
- Headaches
- Numbness of Extremities
- Seizures
- Parkinson's Disease
- Stroke / TIA
- Other:

Dermatologic
- Rashes
- Skin Lesion/Open Wound
- Other:

Musculoskeletal
- Joint Pains
- Muscle Pain
- Jaw Pain
- Neck Pain
- Difficulty Lying Flat
- Other:

Hematologic
- Bruises / Bleeds Easily
- Bleeding Disorder
- Other:

Thyroid
- Hyperthyroid
- Hypothyroid
- Other:

Liver
- Hepatitis A,B,or C
- Cirrhosis
- Other:

Pregnancy Screen
- Are you pregnant? Yes / No
- Currently nursing? Yes / No
- Other:

Other
- History of Mental Illness
- Cancer? Specify_____
- Other:

Social History
- **Do you Smoke?**
- How many packs/day?
- How many years?
- Quit Year:
- **Do you drink alcohol?**
- How often?
- How many per day?
- **Do you use illegal drugs?**
- **Do you use Caffeine?**
- How many cups per day?

Provider Notes

Patient's Signature:_____

Today's Date:_____

Reviewed By / Date:_____/_____

Patient Sticker