Patient Health History Questionarre

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		

(Use back of paper for additional space)

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:

	Condition			Condition	
☐	**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**		☐	**Pacemaker or Defibrillator**	
☐	**Diabetes**	*Type: 1 or 2 Insulin or Meds*	☐	**Seizures**	
☐		*Recent A1c / Blood Sugars:* ___________	☐	**Sleep Apnea**	☐ CPAP
☐	**Emphysema**		☐	**Stent Placement**	*Date:*
☐	**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?**		**Which Eye?**
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	L or R Both

Procedures/Comments:

Patient Sticker

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 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

- [ ] 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

- [ ] *Difficulty Breathing*
- [ ] *Shortness of Breath*
- [ ] Wheezing

Cardiovascular

Yes

- [ ] Chest Pressure or Discomfort
- [ ] Irregular Heartbeat
- [ ] *Palpitations*

Gastrointestinal

- [ ] Abdominal Pain
- [ ] *Difficulty Swallowing*
- [ ] Heartburn
- [ ] Nausea / Vomiting
- [ ] Reflux

Genitourinary

Yes

- [ ] Painful Urination
- [ ] Urgency

Metabolic

- [ ] Heat Intolerance
- [ ] Cold Intolerance

Neurological

- [ ] Balance Disturbance
- [ ] Dizziness
- [ ] Headache
- [ ] Numbness of Extremities

Dermatologic/Integumentary

Yes

- [ ] *Skin Lesion /Open Wound*
- [ ] Rashes

Musculoskeletal

- [ ] *Neck Pain*
- [ ] Back Pain
- [ ] *Difficult to lie flat*
- [ ] Jaw Pain
- [ ] Joint Pain
- [ ] Muscle Weakness

Psychiatric

- [ ] Depressed Mood
- [ ] Hallucinations
- [ ] Stress

Hematologic

- [ ] Bruises Easily
- [ ] Bleeding

Immunologic

- [ ] Enviromental Allergies
- [ ] Seasonal Allergies

Are You Pregnant or Nursing? Y or N

Additional Health comments :

RSC USE ONLY

Reviewed by:

Date:

Patient Sticker