Patient History Questionnaire

Name: _____ Date of Birth: _____

Primary Physician: _____ Address: _____

Previous Ophthalmologist: _____ Address: _____

Referring Physician: _____ Address: _____

Current Medications: _____

_____

Allergies to Medication

List all allergies to medications: _____

_____

REVIEW of SYSTEMS:

Please check YES or NO in bold boxes. If yes, specify in small boxes and explain.

EYE	YES	NO	Explanation of problem (If no, proceed to next topic)
Blurry Vision			
Burning			
Chronic infection of eyes or lids			
Distorted vision			
Double vision			
Dryness			
Excess tearing / watering			
Fluctuating visual acuity			
Foreign body sensation			
Glare / Light sensitivity			
Itching			
Loss of side vision			
Mucous discharge			
Occasional tearing			
Pain or soreness			
Redness			
Sandy or gritty feeling			
Stye, Chalazion			
Tired eyes			
Other			

Are you having any difficulty?	YES	NO	Explanation of problem
Reading small print			
Reading in general			
Recognizing people when close			
Seeing to go up and down steps or curbs			
Driving in bright light			
Driving in the dark			
Reading street / traffic signs			
Doing fine handiwork			
Writing (checks, card, etc)			
Playing games (bingo, cards, etc)			
Playing sports (golf, tennis, etc)			
Doing hobbies			
Watching TV / Movies			
Are you satisfied with your current vision?			
OTHER:			

Eye, History	YES	NO	When Diagnosed	Treatment
Cataract				
Glaucoma				
Eye Muscle problems				
Retina problems				
Corneal problems				
Injury				
Night Blindness				
Other				

Current Eye Medications: _____

_____

Past Eye Surgery

Operation (s) / Laser Treatment (s)	Date
_____	_____
_____	_____
_____	_____

Ear, Nose, Mouth, Throat	YES	NO	Explanation of problem (if no, proceed to next topic)
Sinus congestion / Post-nasal drip			
Difficulty swallowing			
Pain chewing			
Chronic cough			
Dry throat / mouth			
Other			

Cardiovascular	YES	NO	Explanation of problem (if no, proceed to next topic)
Congestive heart failure			
Heart murmur / Mitral Valve prolapse			
Heart attacks			
Other			

Open heart surgery / Angioplasty (describe) _____

_____

Respiratory (Lungs/Breathing)	YES	NO	Explanation of problem (if no, proceed to next topic)
Shortness of breath			
Tuberculosis			
Lung cancer			
Sarcoidosis			
Other			

Surgery _____

_____

Gastrointestinal (Stomach / Intestines)	YES	NO	Explanation of problem (if no, proceed to next topic)
Jaundice/Hepatitis			
Ulcers/Bleeding			
Hiatal Hernia			
Cancer			
Other			

Surgery _____

_____

Genitourinary (Genitals/Kidney/Bladder)

	YES	NO	Explanation of problem (if no, proceed to next topic)
Kidney Disease			
Prostate Cancer			
Cervical/Uterine/Ovarian/Breast Cancer			
Pregnant now?			

Surgery _____

_____

Integumentary (Skin and/or breast)

	YES	NO	Explanation of problem (if no, proceed to next topic)
Skin disease / cancer			
Breast disease / cancer			
Shingles			
Other			

Surgery _____

_____

Musculo-Skeletal

	YES	NO	Explanation of problem (if no, proceed to next topic)
Arthritis			
Broken bones			
Scalp tenderness			
Cancer			
Other			

Surgery _____

_____

Neurological

	YES	NO	Explanation of problem (if no, proceed to next topic)
Fainting			
Convulsions/Seizures/Epilepsy			
Stroke / Paralysis			
Benign tumor			
Cancer			
Alzheimer's			
Other			

Surgery _____

_____

Psychiatric	YES	NO	Explanation of problem (if no, proceed to next topic)
Schizophrenia			
Other			

Hematologic / Lymphatic	YES	NO	Explanation of problem (if no, proceed to next topic)
Anemia			
Sickle Cell disease			
Leukemia / Blood cancer			
Lymphoma			
Swelling			
Enlarged Lymph nodes			

Surgery _____

_____

Allergic / Infectious	YES	NO	Explanation of problem (if no, proceed to next topic)
Head Allergy symptoms			
Hay fever symptoms			
Immune problems			
HIV / AIDS			
Lyme disease			
Other			

Surgery _____

_____

Endocrine	YES	NO	Explanation of problem (if no, proceed to next topic)
Diabetes			
Cancer-pancreas/adrenal glands			
Thyroid problems			
Thyroid cancer			
Hormone replacement therapy			
Other			

Surgery _____

_____

Other

_____ _____

_____ _____

_____ _____

Past Social History

Past History

Describe any other problems, illnesses, surgeries, or medicines that were not described in the above questions.

_____

_____

Social History	YES	NO	Explanation
Toxic exposures			
Recent voyages			
Other			

Date: _____ Patient Signature: _____

Date: _____ Physician Signature: _____

Rosenfeld Kronish Schaffer Jewelewicz Winnick Glatzer Werner Gonzalez Saitowitz