

PATIENT HISTORY QUESTIONNAIRE

DATE \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_
Address \_\_\_\_\_
Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_
SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_
Occupation \_\_\_\_\_ Employer \_\_\_\_\_
Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_
Family Physician \_\_\_\_\_ Date of Last Eye Exam \_\_\_\_\_

Ethnicity: \_\_\_ African/American \_\_\_ Asian \_\_\_ Caucasian \_\_\_ Hispanic \_\_\_ Native American \_\_\_ Other

PATIENT PAST MEDICAL HISTORY

- YES NO
\_\_\_ \_\_\_ Angina
\_\_\_ \_\_\_ Arrhythmia
\_\_\_ \_\_\_ Congestive Heart
\_\_\_ \_\_\_ Heart Attack
\_\_\_ \_\_\_ Heart Disease
\_\_\_ \_\_\_ High Blood Pressure
\_\_\_ \_\_\_ Phlebitis
\_\_\_ \_\_\_ Stroke
\_\_\_ \_\_\_ Diabetes Type I / Type II
\_\_\_ \_\_\_ Thyroid -Hyper / Hypo
\_\_\_ \_\_\_ Liver Disease
\_\_\_ \_\_\_ Hiatal Hernia
\_\_\_ \_\_\_ Kidney Disease
\_\_\_ \_\_\_ Anemia Type: \_\_\_\_\_
\_\_\_ \_\_\_ Arthritis: Rheum, Osteo, Other \_\_\_\_\_
\_\_\_ \_\_\_ Asthma
\_\_\_ \_\_\_ Bronchitis
\_\_\_ \_\_\_ Emphysema
\_\_\_ \_\_\_ Pneumonia
\_\_\_ \_\_\_ Tuberculosis
\_\_\_ \_\_\_ Claustrophobia
\_\_\_ \_\_\_ Rheumatic Fever
\_\_\_ \_\_\_ Other

REVIEW OF SYMPTOMS

- YES NO Do you have these now?
\_\_\_ \_\_\_ Hearing Loss - Total RT/LT Partial RT/LT
\_\_\_ \_\_\_ Dizziness/Fainting \_\_\_\_\_
\_\_\_ \_\_\_ Dentures \_\_\_\_\_
\_\_\_ \_\_\_ Headaches / Migraines
\_\_\_ \_\_\_ Shortness of Breath \_\_\_\_\_
\_\_\_ \_\_\_ Cough \_\_\_\_\_
\_\_\_ \_\_\_ Wheezing \_\_\_\_\_
\_\_\_ \_\_\_ Chest Pain \_\_\_\_\_
\_\_\_ \_\_\_ Skipped beats/palpitation \_\_\_\_\_
\_\_\_ \_\_\_ Ulcers/abdominal pain \_\_\_\_\_
\_\_\_ \_\_\_ Swelling in Feet \_\_\_\_\_
\_\_\_ \_\_\_ Leg Cramps \_\_\_\_\_
\_\_\_ \_\_\_ Tremor \_\_\_\_\_
\_\_\_ \_\_\_ Difficulty lying flat \_\_\_\_\_

PRESENT MEDICATIONS & VITAMINS (strength/dose)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HOSPITALIZATIONS

List prev hosp and surgeries
Thyroid/neck \_\_\_\_\_
Heart \_\_\_\_\_
Lung \_\_\_\_\_
Stomach/abdomen \_\_\_\_\_
Other \_\_\_\_\_

ALLERGIES /Reaction \_\_\_\_\_ No Known Allergies

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FAMILY HISTORY

Diabetes Y/N Relation \_\_\_\_\_
Heart Disease Y/N Relation \_\_\_\_\_
High Blood Pressure Y/N Relation \_\_\_\_\_
Macular Degeneration Y/N Relation \_\_\_\_\_
Cataracts Y/N Relation \_\_\_\_\_
Glaucoma Y/N Relation \_\_\_\_\_
Retinal Detachment Y/N Relation \_\_\_\_\_
Other Eye Conditions \_\_\_\_\_

EYE INFORMATION

Eye Surgeries Y/N Type/Date/Surgeon \_\_\_\_\_
Eye Injuries Y/N Kind/Date \_\_\_\_\_

SOCIAL HISTORY

Alcohol Use : \_\_\_ Never \_\_\_ Rare \_\_\_ Mod \_\_\_ Daily \_\_\_ Social \_\_\_ Beer \_\_\_ Wine \_\_\_ Liquor \_\_\_
Tobacco Use: \_\_\_ Never Yr Quit \_\_\_ Use/Day: Cigarettes \_\_\_ Cigars \_\_\_ Pipe \_\_\_ Chewing Tobacco \_\_\_
Drug Use : \_\_\_ Never Type/freq Cocaine \_\_\_ Heroin \_\_\_ Marijuana \_\_\_ Meth \_\_\_ Speed \_\_\_