Patient Health History Questionnaire

Name:			Date:
Date of Birth:	Height:	Weight:	Sex: M / F

Please list any MEDICATIONS/SUPPLEMENTS, otherwise mark ❒ NO MEDICATIONS

	Name	Dosage	Reason
1.			
2.			
3.			
4.			
5.			
6.			

Please list any DRUG ALLERGIES, otherwise mark ❒ NO KNOWN DRUG ALLERGIES

	Name	Please describe the reaction
1.		
2.		
3.		

Please indicate any MEDICAL CONDITIONS, otherwise mark ❒ NO MEDICAL CONDITIONS

❒ **Asthma**		❒ **Kidney Disease**	❒ Dialysis
❒ **Autoimmune Disease**	Type:	❒ **Liver Disease**	
❒ **Cancer**	Type:	❒ **Migraines**	
❒ **COPD**		❒ **Pregnant or Nursing**	
❒ **Diabetes**	Type: A1c:	❒ **Seizures**	
❒ **Emphysema/Bronchitis**		❒ **Sleep Apnea**	❒ CPAP
❒ **Heart Attack**	Date:	❒ **Stroke/TIA**	
❒ **Heart Disease**	Cardiologist:	❒ **Thyroid Disease**	Type:
❒ **Hepatitis A, B, or C**	❒ Cirrhosis	❒	
❒ **High Blood Pressure**		❒	
❒ **High Cholesterol**		❒	

Please indicate any MEDICAL PROCEDURES, otherwise mark ❒ NO MEDICAL PROCEDURES

❒ **Coronary Bypass**	Date:	❒	Date:
❒ **Coronary Stent**	Date:	❒	Date:
❒ **Defibrillator**	Date:	❒	Date:
❒ **Pacemaker**	Date:	❒	Date:

Please indicate any OCULAR HISTORY, otherwise mark ❒ NO OCULAR HISTORY

❒ **Amblyopia** Right/Left		❒ **Retinal Laser (in office)** Right/Left	Date:
❒ **Cataract Surgery** Right/Left	Date:	❒ **Retinal Surgery (in OR)** Right/Left	Date:
❒ **LASIK** Right/Left	Date:	❒	
❒ **Glaucoma** Right/Left		❒	
❒ **Retinal Detachment** Right/Left		❒	

Name:	Date of Birth:	Date:

Please indicate any FAMILY HISTORY, otherwise mark ❒ UNKNOWN FAMILY HISTORY (for non-immediate family members, please indicate if relation is Paternal or Maternal)			
❒ **Blindness**	Relation:	❒ **High Cholesterol**	Relation:
❒ **Cancer** Type:	Relation:	❒ **Macular Degeneration**	Relation:
❒ **Diabetes**	Relation:	❒ **Retinal Detachment**	Relation:
❒ **Glaucoma**	Relation:	❒ **Stroke**	Relation:
❒ **Heart Disease**	Relation:	❒	Relation:
❒ **High Blood Pressure**	Relation:	❒	Relation:

SOCIAL HISTORY (please mark Yes or No for each category)			
Do you drink alcohol?	Yes / No	If yes, how much per day or week?	
Do you drink caffeine?	Yes / No	If yes, how much per day or week?	
Do you currently smoke?	Yes / No	If yes, how much per day or week?	
If no, did you used to smoke?	Yes / No	If yes, how much per day or week?	Quit year?
Do you use recreational drugs?	Yes / No	If yes, how much per day or week?	

Review of Systems (please mark any symptoms that you are dealing with *currently*)		
Constitutional	**Cardiovascular**	**Dermatologic/Integumentary**
❒ **Fatigue**	❒ **Chest Pressure or Discomfort**	❒ **Open Wound**
❒ **Fever**	❒ **Irreg. Heartbeat/Palpitations**	❒ **Rash**
❒ **Recent Cold/Flu**	**Gastrointestinal**	❒ **Skin Lesion**
❒ **Weight Gain**	❒ **Abdominal Pain**	**Musculoskeletal**
❒ **Weight Loss**	❒ **Difficulty Swallowing**	❒ **Back Pain**
Head/Eyes/Ears/Nose/Throat	❒ **Heartburn**	❒ **Neck Pain**
❒ **Blurred Vision**	❒ **Nausea**	❒ **Jaw Pain**
❒ **Blind Spot or Scotoma**	❒ **Reflux**	❒ **Joint Pain**
❒ **Double Vision**	❒ **Vomiting**	❒ **Muscle Weakness**
❒ **Eye Pain**	**Genitourinary**	**Psychiatric**
❒ **Hearing Loss**	❒ **Painful Urination**	❒ **Depressed Mood**
❒ **Floaters**	❒ **Urgency**	❒ **Hallucinations**
❒ **Sinus Problems**	**Metabolic**	❒ **Stress**
❒ **Sore Throat**	❒ **Cold Intolerance**	**Hematologic**
❒ **Tinnitus or Ringing of Ears**	❒ **Heat Intolerance**	❒ **Bleeding**
❒ **Vision Loss**	**Neurologic**	❒ **Bruising**
Respiratory	❒ **Balance Disturbances**	**Immunologic**
❒ **Difficulty Breathing (Resting)**	❒ **Dizziness**	❒ **Environmental Allergies**
❒ **Shortness of Breath (Activity)**	❒ **Headache**	❒ **Seasonal Allergies**
❒ **Wheezing**	❒ **Numbness of Extremities**	
	❒ **Seizures**	
	❒ **Vertigo**	