

PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____

Date: / /

Family Physician Name: _____

Do you currently see an ophthalmologist, rheumatologist or endocrinologist? If so, please list the name of your doctor: _____

MEDICATIONS:

Do you have any allergies to medications? No Yes If yes, please list: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and vitamins): _____

List any ocular medications you use (including oral medications, eye drops, eye ointments, etc.): _____

SOCIAL: Do you use any of the following?	Y	N	Please Specify /Amount Used
Cigarettes			
Tobacco			
Alcohol			
Illegal Drugs			
Have you ever been infected with a STD?			

SYSTEMIC/OCULAR SURGERIES:			
Have you had any surgeries (including eye surgeries/injuries)?			
<input type="checkbox"/> Y <input type="checkbox"/> N			
What Kind? (please list)	When?		

MEDICAL HISTORY: (ROS) Do you currently, or have you ever had any problems in the following areas?

Y N If yes, please list condition.				Y N If yes, please list condition.			
CONSTITUTIONAL	Fever, Weight Loss or Gain			INTEGUMENTARY	Skin		
CARDIOVASCULAR	Heart Condition			ENDOCRINE	Diabetes		
	High Blood Pressure				Thyroid		
	Cardiovascular Disease			IMMUNOLOGIC			
GASTROINTESTINAL	Diarrhea			HEAD	Sinusitis		
	Constipation				Chronic Cough		
RESPIRATORY	Asthma				Dry Mouth		
	Chronic Bronchitis			ALLERGY	Seasonal/ Enviromental		
	Emphysema						
HEMATOLOGIC/LYMPHATIC	Anemia			OCULAR HISTORY:		Y	N
	Bleeding Problems			Cataracts			How long?
PSYCHIATRIC				Dry Eye			
NEUROLOGICAL	Headaches			Eye Infections			
	Migraines			Eye Turn			
	Seizures			Glaucoma			
GENITOURINARY	Genitals/ Kidney/ Bladder			Macular Degeneration			
MUSCULOSKELETAL	Rheumatoid Arthritis			Retinal Disease			
	Muscle Pain						
	Joint Pain			OTHER :			

SYSTEMIC FAMILY HISTORY:	Y	N	Relationship
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Thyroid Disease			

OCULAR FAMILY HISTORY:	Y	N	Relationship
Blindness			
Cataract			
Eye Turn			
Glaucoma			
Macular Degeneration			
Retinal Detachment/Disease			

Patient Signature: _____