Patient History Questionnaire

Name ______________________________ Birth date ______________

Name of referring physician ______________________ Physician phone ______________

Physician Address ______________________ Date of last eye exam ______________

History of Present Illness (elements):

____ Location ____ Quality ____ Severity ____ Modifying Factors

____ Timing ____ Duration ____ Context ____ Associated Signs & Symptoms

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If "yes," provide information.

	YES	NO	Explanation of Problem
Constitutional Symptoms	☐	☐	
Fever	☐	☐	
Weight loss	☐	☐	
Other	☐	☐	
Eyes	☐	☐	
Loss of vision	☐	☐	
Blurred vision	☐	☐	
Distorted vision (halos)	☐	☐	
Loss of side vision	☐	☐	
Double vision	☐	☐	
Dryness	☐	☐	
Mucous discharge	☐	☐	
Redness	☐	☐	
Sandy or gritty feeling	☐	☐	
Itching	☐	☐	
Burning	☐	☐	
Foreign body sensation	☐	☐	
Excess tearing/watering	☐	☐	
Occasional tearing	☐	☐	
Glare/Light sensitivity	☐	☐	
Eye pain or soreness	☐	☐	
Chronic infection of eye or lid	☐	☐	
Sties, Chalazion	☐	☐	
Fluctuating visual acuity	☐	☐	
Tired eyes	☐	☐	

(continued)

	YES	NO	Explanation of Problem
Ears, nose, mouth, throat	☐	☐	______
Sinus congestion	☐	☐	______
Runny nose	☐	☐	______
Post-nasal drip	☐	☐	______
Chronic cough	☐	☐	______
Dry throat/mouth	☐	☐	______
Cardiovascular (heart/blood vessels)	☐	☐	______
Respiratory (lungs/breathing)	☐	☐	______
Chronic bronchitis	☐	☐	______
Gastrointestinal (stomach/intestines)	☐	☐	______
Genitourinary (genitals/kidney/bladder)	☐	☐	______
Musculoskeletal	☐	☐	______
Muscle	☐	☐	______
Joint	☐	☐	______
Integumentary (skin and/or breast)	☐	☐	______
Neurological	☐	☐	______
Psychiatric	☐	☐	______
Endocrin	☐	☐	______
Hematologic/Lymphatic	☐	☐	______
Blood	☐	☐	______
Lymph nodes	☐	☐	______
Swelling	☐	☐	______
Allergic/Immunologic	☐	☐	______
Head allergy symptoms	☐	☐	______
Seasonal allergies	☐	☐	______
Hay fever symptoms	☐	☐	______
Are immunizations up to date?	Y	N	______

PAST HISTORY

List any medications you currently take ______________________________

____

List all major illnesses and injuries ______________________________

____

____

(continued)

List any surgeries you have had ______________________________

____

____

Have you had crossed eyes, lazy eye, drooping eyelid, prominent eyes?

____

____

Do you have allergies to any medications? ☐ YES ☐ NO

If YES, list medications ______________________________

____

____

FAMILY HISTORY

DISEASE	YES	NO	Relationship to Patient
Blindness	☐	☐	
Cataract	☐	☐	
Glaucoma	☐	☐	
Macular degeneration	☐	☐	
Retinal detachment	☐	☐	
Arthritis	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart attacks	☐	☐	
High blood pressure	☐	☐	
Kidney disease	☐	☐	
Lupus	☐	☐	
Sjogrens Syndrome	☐	☐	
Stroke	☐	☐	
Thyroid disease	☐	☐	
Tuberculosis	☐	☐	
Other	☐	☐	

(continued)

SOCIAL HISTORY

MARITAL STATUS: S M W D SEP

Current occupation ______________________________

Do you drive? ☐ YES ☐ NO

Do you have visual difficulty when driving? ☐ YES ☐ NO

Do you have problems with night vision? ☐ YES ☐ NO

Have you ever tried to wear contacts? ☐ YES ☐ NO

____

Do you currently wear glasses? ☐ YES ☐ NO

If YES, how long have you had the current prescription? ______________________________

Do you drink alcohol? ☐ YES ☐ NO

If YES, how often? ______________________________

Do you smoke? ☐ YES ☐ NO

If YES, how many packs a day ______________________________

Have you ever had a blood transfusion? ☐ YES ☐ NO

Have you ever been in intimate contact with a person who had a sexually transmitted disease? ☐ YES ☐ NO

History reviewed. ☐ No changes ☐ Additions as noted above

Physician's signature: ______________________________ Date: ______________