Eastern Sierra Eyecare

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& Assoicates

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Health History Questionnaire

Name: ☐ M ☐ F	DOB:
Today's Date:	Email Address:

Medications:			
List your prescribed drugs and over-the-counter drugs, including vitamins and inhalers.			
Name of the Drug	Strength	Dose	Frequency Taken

Allergies to medications ☐ Yes ☐ No	
Name the Drug or Allergen	**Reaction You Had**

Allergies ☐ Yes ☐ No	
Food or Latex	**Reaction You Had**

Review of Systems		
Check if you currently have, or have had, any symptoms in the following areas to a significant degree.		
Constitution	**Ear Nose and Throat**	**Psychiatric**
☐ None	☐ None	☐ None
☐ Developmental Disabilities	☐ Dry Mouth	☐ Anxiety Disorder
☐ Fatigue Syndrome	☐ Sinusitis	☐ Bipolar Disorder
☐ Cancer	☐ Laryngitis	☐ Attention Deficit
☐ Unexpected Weight Loss/Gain	☐ Hearing Loss	☐ Depression
☐ Other	☐ Other	☐ Other
Neurological	**Cardiovascular**	**Respiratory**
☐ None	☐ None	☐ None
☐ Stroke/CVA	☐ Hypertension	☐ Bronchitis
☐ Tumor	☐ Stroke/CVA	☐ Emphysema
☐ Migraine	☐ Heart Disease	☐ Cigarette Smoker
☐ Multiple Sclerosis	☐ Vascular Disease	☐ Asthma
☐ Cerebral Palsy	☐ Congestive Heart Failure	☐ Chronic Obstruction
☐ Epilepsy	☐ Other	☐ Sleep Apnea
☐ Other		☐ Other

Gastrointestinal
- ☐ None
- ☐ Acid Reflux
- ☐ Ulcer
- ☐ Colitis
- ☐ Crohn's
- ☐ Celiac Disease
- ☐ Other

Genitourinary
- ☐ None
- ☐ Chlamydia
- ☐ Herpes
- ☐ Kidney Disease
- ☐ Prostate Disease/Cancer
- ☐ STD – Herpetic/Chlamydia
- ☐ Benign Prostate Hypertrophy
- ☐ Other

Musculoskeletal
- ☐ None
- ☐ Osteoporosis
- ☐ Gout
- ☐ Ankylosing Spondylitis
- ☐ Muscular Dystrophy
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Other

Integumentary
- ☐ None
- ☐ Eczema
- ☐ Negative
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Herpes Zoster (Shingles, Chicken Pox)
- ☐ Herpes Simplex (Cold Sores)
- ☐ Other

Endocrine
- ☐ None
- ☐ Hormonal Dysfunction
- ☐ Type 1 Diabetes Mellitus
- ☐ Type 2 Diabetes Mellitus
- ___ Fasting Blood Sugar
- ___ HbA1C
- ☐ Thyroid Dysfunction
- ☐ Other

Hematologic/Lymphatic
- ☐ None
- ☐ Anemia
- ☐ Large-volume blood loss
- ☐ Ulcer
- ☐ Hypercholesteremia
- ☐ Other

Allergic/Immune
- ☐ None
- ☐ Lupus
- ☐ Other
- ☐ Rheumatoid Arthritis
- ☐ Drug Allergies
- ☐ Sjogren's Syndrome
- ☐ Environmental Allergies

History

Personal Ocular
- ☐ None
- ☐ Eye Surgery
- ☐ Age-related Macular Degeneration
- ☐ Cataract
- ☐ Glaucoma
- ☐ Glaucoma Suspect
- ☐ Amblyopia (Lazy Eye)
- ☐ Strabismus (Eye Turn)
- ☐ Inflammatory Disorders
- ☐ Injury
- ☐ Dry Eye
- ☐ Retinal Hole/Tear/Detachment
- ☐ Nystagmus (Rapid Eye Movement)
- ☐ Retinal Degeneration
- ☐ Keratoconus
- ☐ Other

Family

	Member of Family
☐ None	_____
☐ Hypertension	_____
☐ Hypothyroidism	_____
☐ Hyperthroidism	_____
☐ Diabetes Type 1	_____
☐ Diabetes Type 2	_____
☐ Cancer	_____
☐ Other	

Family Ocular History

	Member of Family
☐ None	_____
☐ Dry Eye	_____
☐ Nystagmus (Rapid Eye Movement)	_____
☐ Strabismus (Eye Turn)	_____
☐ Retinal Detachment	_____
☐ Cataract	_____
☐ Glaucoma	_____
☐ Glaucoma Suspect	_____
☐ Amblyopia (Lazy Eye)	_____
☐ Macular Degeneration	_____
☐ Severe Hyperopia	_____
☐ Severe Myopia	_____

Social History

Alcohol Use ☐ Yes ☐ No
- ☐ None
- ☐ Social use Only
- ☐ 1-2 Drink Daily
- ☐ Above Average
- ☐ Alcohol Dependence

Tobacco Use ☐ Yes ☐ No
- ☐ Smokes Cigarettes
- ☐ Smokes Cigars
- ☐ Smokes Pipe
- ☐ Uses Smokeless Tobacco
- ☐ Other

Amount:

Smoking Status
- ☐ Never Smoked
- ☐ Former Smoker
- ☐ Current Some Day Smoker
- ☐ Current Every Day Smoker

Signature:_____ Date:_____