PATIENT HISTORY QUESTIONNAIRE

Patient Name: **D.O.B:** / / **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)?** ☐ **Y** ☐ **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.
CONSTITUTIONAL	Fever, Weight Loss or Gain			
CARDIOVASCULAR	Heart Condition			
	High Blood Pressure			
	Cardiovascular Disease			
GASTROINTESTINAL	Diarrhea			
	Constipation			
RESPIRATORY	Asthma			
	Chronic Bronchitis			
	Emphysema			
	Sleep Apnea			
HEMATOLOGIC/LYMPHATIC	Anemia			
	Bleeding Problems			
PSYCHIATRIC				
NEUROLOGICAL	Headaches			
	Migraines			
	Seizures			
GENITOURINARY	Genitals/ Kidney/ Bladder			
MUSCULOSKELETAL	Rheumatoid Arthritis			
	Muscle Pain			
	Joint Pain			

		Y	**N**	If yes, please list condition.
INTEGUMENTARY	Skin			
ENDOCRINE	Diabetes			
	Thyroid			
IMMUNOLOGIC				
HEAD	Sinusitis			
	Chronic Cough			
	Dry Mouth			
ALLERGY	Seasonal/ Enviromental			

OCULAR HISTORY:	**Y**	**N**	How long?
Cataracts			
Dry Eye			
Eye Infections			
Eye Turn			
Glaucoma			
Macular Degeneration			
Retinal Disease			

OTHER :

SYSTEMIC FAMILY HISTORY: **Any family history of the following?**	**Y**	**N**	**Relationship**
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Thyroid Disease			

OCULAR FAMILY HISTORY: **Any family history of the following?**	**Y**	**N**	**Relationship**
Blindness			
Cataract			
Eye Turn			
Glaucoma			
Macular Degeneration			
Retinal Detachment/Disease			

Patient Signature:_____