FLAGSTAFF VISION

1505 S. Yale Street, Flagstaff, AZ 86001

Returning Patient History Questionnaire

Welcome back to our office!

First Name _____ Last Name _____ Today's Date _____

Cell Number _____ Home Number _____ Work/Day Number _____ EXT _____

Email _____ Date of Birth _____ SS# _____

Address** _____ City _____ State _____ Zip _____

**Any address change since your last visit? ☐ NO

List all medications: ☐ None ☐ See List

Allergies to medications: ☐ NO Known Drug Allergies

Pharmacy Name _____ Primary Care Physician _____

Pharmacy Location _____ Referred By _____

Review of Systems:

General (fever, fatigue, weight loss)	☐ No ☐ Yes	_____
Cardiovascular (blood pressure, heart problems)	☐ No ☐ Yes	_____
Respiratory (asthma, emphysema)	☐ No ☐ Yes	_____
Gastrointestinal (intestinal disease, stomach ulcer)	☐ No ☐ Yes	_____
Genital, Kidney, Bladder, Prostate	☐ No ☐ Yes	_____
Muscles, Joints, Bones (arthritis, pains)	☐ No ☐ Yes	_____
Integumentary (skin: acne, warts, skin cancer)	☐ No ☐ Yes	_____
Neurological (strokes, brain tumors, multiple sclerosis)	☐ No ☐ Yes	_____
Psychiatric (anxiety, depression, insomnia)	☐ No ☐ Yes	_____
Endocrine (diabetes, thyroid)	☐ No ☐ Yes	_____
Blood/Lymphatics (anemia, bleeding problems)	☐ No ☐ Yes	_____
Are you pregnant or breastfeeding?	☐ No ☐ Yes	_____
Do you have AIDS or are HIV positive?	☐ No ☐ Yes	_____

Social History:

Do you use tobacco products? ☐ No ☐ Yes

If yes, how long? _____

Do you drink alcohol? ☐ No ☐ Yes

If yes, how often? _____

Family History:

Do any medical or eye diseases run in your family? ☐ No ☐ Yes

Diabetes, Blindness, High blood pressure, Cancer, Cataract, Glaucoma, Macular Degeneration &/or Retinal Detachment?

Details: _____

Patient's Sig: _____ Date: _____

Patient's Sig: _____ Date: _____

Patient's Sig: _____ Date: _____

History and ROS reviewed

Doctor's Sig: _____ Date: _____

Doctor's Sig: _____ Date: _____

Doctor's Sig: _____ Date: _____