PATIENT HISTORY QUESTIONNAIRE

Name_____ Date_____

Do you currently have any problems in the following areas?

	YES	NO	IF YES, EXPLANATION OF PROBLEM
CONSTITUTIONAL SYMPTOMS			
Fever	____	____	_____
Weight Loss	____	____	_____
Other	____	____	_____
EYES			
Loss Of Vision	____	____	_____
Blurred Vision	____	____	_____
Distorted Vision	____	____	_____
Loss Of Side Vision	____	____	_____
Double Vision	____	____	_____
Sandy or Gritty Feeling	____	____	_____
Itching, Burning	____	____	_____
Excess tearing/watering	____	____	_____
Glare/Light sensitivity	____	____	_____
Eye pain or soreness	____	____	_____
Infection of eye or lid	____	____	_____
Do you wear glasses?	____	____	_____
Do you wear contacts?	____	____	_____
EARS, NOSE, MOUTH, THROAT			
Sinus Congestion	____	____	_____
Chronic Cough	____	____	_____
CARDIOVASCULAR (HEART)	____	____	_____
RESPIRATORY (LUNGS)	____	____	_____
GASTROINTESTINAL	____	____	_____
URINARY	____	____	_____
INTEGUMENTARY(skin,breast)	____	____	_____
Mass/Tumors	____	____	_____
Rash	____	____	_____
NEUROLOGICAL	____	____	_____
PSYCHIATRIC	____	____	_____
HEMATOLOGIC/LYMPHATIC			
Anemia/blood disease	____	____	_____
Swollen lymph nodes	____	____	_____
ALLERGIC/IMMUNOLOGIC			
Head allergy symptoms	____	____	_____

List any medications you currently take:

_____

_____

_____

Do you have allergies to any medications? **Yes____** **No____**
If YES, list medications: _____

_____

List all major medical conditions:
Asthma/Emphysema_____ Diabetes_____ High Blood Pressure_____
Heart Disease_____ Other_____

List any surgeries you have had:

_____

_____

Is there FAMILY HISTORY of:

	Yes	No	Relationship to Patient
Blindness	___	___	_____
Cataract	___	___	_____
Glaucoma	___	___	_____
Macular Degeneration	___	___	_____
Retinal Detachment	___	___	_____
Arthritis	___	___	_____
Diabetes	___	___	_____
High Blood Pressure	___	___	_____
Other_____	___	___	_____
Do you drink alcohol?	___	___	_____
If YES, how often?			_____
Do you smoke?	___	___	
If YES, how many packs a day?			_____

_____ _____

Patient's Signature **Date**

_____ _____

Physician's Signature **Date**