PATIENT HISTORY QUESTIONNAIRE

Review of systems

Name: ____ Date of birth: ________________

Do you / your child currently have any problems in the following areas? If "Yes", provide information.

Symptoms	Yes	No	Explanation of problems
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 -eye/lid	☐	☐	________________
Sties, chalazian	☐	☐	________________
Fluctuating visual acuity	☐	☐	________________
Tired eyes	☐	☐	________________
Hematologic			
Blood	☐	☐	________________
Lymph nodes	☐	☐	________________
swelling	☐	☐	________________

Symptoms	Yes	No	Expanation of problems
Allergic/Immunologic			
Head allergy symptoms	☐	☐	________________
Seasonal/hay fever	☐	☐	________________
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	☐	☐	________________
Endocrine	☐	☐	________________

PAST HISTORY

List Any Medications you currently take____ _______

____ _______

List all major illnesses and injuries ______________________________________ _________ _______

____ _______

List any surgeries you have had ____ _______

Have you ever had crossed eyes, lazy eye, drooping eyelid, and or 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	☐	☐	________________________
Macular degeneration	☐	☐	________________________
Retinal detachment	☐	☐	________________________
High blood pressure	☐	☐	________________________
Kidney disease	☐	☐	________________________
Siogren syndrome	☐	☐	________________________
Thyroid disease	☐	☐	________________________
Glaucoma	☐	☐	________________________
Arthritis	☐	☐	________________________
Cancer	☐	☐	________________________
Diabetes	☐	☐	________________________
Heart attacks	☐	☐	________________________
Lupus	☐	☐	________________________
Stroke	☐	☐	________________________
Tuberculosis	☐	☐	________________________
Other	☐	☐	________________________

SOCIAL HISTORY

Curent occupation / School year ____

Do you drive? ☐ Yes ☐ No Do you have 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 old is the prescription?________

Do you drink alcohol? ☐ Yes ☐ No If so, How often? ___________________________

Do you smoke? ☐ Yes ☐ No If yes, How many packs a day?_______________

Have you ever been in inmate contact with a person who had a sexually transmitted disease?

☐ Yes ☐ No ☐ N/A

History reviewed ☐ No changes ☐ Additions as noted above

Physicians's Signature __________________________ Date _________________________