

Patient Health History Questionnaire

Name: _____ Date of Birth: _____ Date: _____

Current Height: _____ Weight: _____ Age: _____ Sex: M / F

Medications: Please List all Medications and Supplements You Are Taking

Name:	Dosage / Frequency	Why are you taking this?
<input type="radio"/> No Medications		
1		
2		
3		
4		
5		
6		

(Use back of paper for additional space)

Allergies /Sensitivities: Describe the reaction?

<input type="radio"/> No Known Drug Allergies	
1	
2	
3	
4	

Medical Conditions: Please List All Past/Current Medical Conditions

No Medical Conditions	Date	How was or is this treated?
<input type="radio"/>		
1		
2		
3		
4		

Please Mark if you have a history of the following conditions and give a brief explanation:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis A,B, or C	<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Autoimmune Disease <i>Type:</i>	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Cancer <i>Type:</i>	<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Dialysis
<input type="checkbox"/> COPD	<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Coronary Bypass or Stent <i>Date:</i>	<input type="checkbox"/> Pacemaker or Defibrillator	
<input type="checkbox"/> Diabetes <i>Type: 1 or 2 Insulin or Meds</i>	<input type="checkbox"/> Pregnant or Nursing	
<input type="checkbox"/> <i>Recent A1c / Blood Sugars: _____</i>	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Emphysema / Bronchitis	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> CPAP
<input type="checkbox"/> Heart Attack <i>Date:</i>	<input type="checkbox"/> Stroke / TIA	<i>Date:</i>
<input type="checkbox"/> Heart Disease <i>Cardiologist:</i>	<input type="checkbox"/> Thyroid Disease	<i>Type: Hypo or Hyper</i>

Please list ALL known Procedures /Surgeries, or use this space for Comments:

Past Ocular History	Which Eye?	Date:	Which Eye?	Date:
Cataract Surgery	L or R Both		Macular Degeneration	L or R Both
Glaucoma	L or R Both		Diabetic Retinopathy	L or R Both
Amblyopia	L or R Both		Retinal Detachment	L or R Both
LASIK	L or R Both		Vitrectomy	L or R Both

Procedures/Comments:

Patient Sticker

Patient Name:

Date of Birth:

Family Medical History			Social History		
○Unknown Family History	Yes	Relation?			Yes How Often per Week or Day?
Amblyopia			Do you:		
Arthritis			Drink Alcohol?		
Diabetes			Drink Caffeine?		
Glaucoma					
Cancer			Currently Smoke?		
Heart Disease			(Are you a) Former Smoker?		
Macular Degeneration			Quit Year?		
Stroke					
Thyroid Disease			Use Recreational/Illegal Drugs?		
Other:					

Do you use an Oxygen Tank? Y or N **Require use of a Wheelchair?** Y or N

<u>Review of Systems</u>		
Mark Yes if you CURRENTLY experience these symptoms		
Constitutional	Cardiovascular	Dermatologic/Integumentary
Yes	Yes	Yes
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Chest Pressure or Discomfort	<input type="checkbox"/> Skin Lesion /Open Wound
<input type="checkbox"/> Fever	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Rashes
<input type="checkbox"/> Weight Loss/Gain	<input type="checkbox"/> Palpitations	Musculoskeletal
<input type="checkbox"/> Recent Cold/ Flu	Gastrointestinal	<input type="checkbox"/> Neck Pain
HEENT	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Difficult to lie flat
<input type="checkbox"/> Double vision	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Jaw Pain
<input type="checkbox"/> Floaters	<input type="checkbox"/> Nausea / Vomiting	<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Reflux	<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Tinnitus or Ringing of Ears	Genitourinary	Psychiatric
<input type="checkbox"/> Scotoma or Blind Spot	Yes	<input type="checkbox"/> Depressed Mood
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Urgency	<input type="checkbox"/> Stress
<input type="checkbox"/> Vertigo	Metabolic	Hematologic
<input type="checkbox"/> Vision changes	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Bruises Easily
<input type="checkbox"/> Vision loss	<input type="checkbox"/> Cold Intolerance	<input type="checkbox"/> Bleeding
Respiratory	Neurological	Immunologic
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Balance Disturbance	<input type="checkbox"/> Environmental Allergies
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Headache	
	<input type="checkbox"/> Numbness of Extremities	

Additional Health comments :

RSC USE ONLY	Patient Sticker
Reviewed by:	
Date:	