



## PATIENT HEALTH HISTORY QUESTIONNAIRE

Please answer all questions.

NAME: \_\_\_\_\_

Today's Date: \_\_\_\_\_

AGE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

### MEDICAL INFORMATION

Do you have problems with any of these systems? (Please circle yes or no.)

DIABETES	Yes / No	GASTROINTESTINAL	Yes / No
HIGH BLOOD PRESSURE	Yes / No	EARS/NOSE/THROAT	Yes / No
HEART DISEASE	Yes / No	CARDIOVASCULAR	Yes / No
ARTHRITIS	Yes / No	RESPIRTORY	Yes / No
CANCER	Yes / No	GENITOURINARY	Yes / No
DERMATOLOGIC	Yes / No	KIDNEY STONES	Yes / No
STEROID USE	Yes / No	BLOOD/LYMPH	Yes / No
HEADACHES	Yes / No	OTHER ILLNESS	Yes / No

Allergies to Medications: Yes / No Please List: \_\_\_\_\_

\_\_\_\_\_

Current medications please List: \_\_\_\_\_

\_\_\_\_\_

Eye Medications: \_\_\_\_\_

Do you use Alcohol? Yes / No How much in one week? \_\_\_\_\_

Do you use Tobacco? Yes / No How much in one week? \_\_\_\_\_

### FAMILY HISTORY

High blood pressure	Yes / No	Relation	_____
Diabetes	Yes / No	Relation	_____
Macular degeneration	Yes / No	Relation	_____
Glaucoma	Yes / No	Relation	_____
Retinal detachment	Yes / No	Relation	_____
Cataracts	Yes / No	Relation	_____
Blindness	Yes / No	Relation	_____
Other	Yes / No	Relation	_____

### PERSONAL EYE HISTORY

Have you had any eye injury? Yes / No What Kind? \_\_\_\_\_ Date \_\_\_\_\_

Have you had any eye operations? Yes/No What Kind? \_\_\_\_\_ Date \_\_\_\_\_

(Please circle.)

Do you have Glaucoma? Cataracts? Retinal detachment? Macular degeneration?

Dry Eyes? Blurred Vision? Lazy Eye/Crossed Eye

Do you wear glasses? Yes/No Do you wear Contacts? Yes/No

UPDATED \_\_\_\_\_

UPDATED \_\_\_\_\_