History & Information Questionnaire

PATIENT NAME: _________________________________ **DATE: ______________**
CHART NUMBER: ______________
Please answer the following questions regarding your medical history and current health status. **(Please mark all that apply)**
Primary Doctor: ______________________________________
Referral Doctor: ______________________________________

Past medical History
A. Have you ever been treated for any of the following medical conditions?

[ ] High Blood Pressure [ ] Heart Problems [ ] Lung Disease [ ] High Cholesterol
[ ] Diabetes [ ] Arthritis [ ] Stroke [ ] Hepatitis
Insulin/non-insulin [ ] Asthma [ ] Liver Disease [ ] Other_________
[ ] Kidney Diseases/ Stones [ ] Cancer [ ] Thyroid [ ] None
B. Have you ever had any eye disease?
[ ] Glaucoma [ ] Cataracts [ ] Wandering or lazy eye [ ] None
[ ] Retinal Problems [ ] Macular Degeneration [ ] Other __________

Family History
C. Do any medical or eye diseases run in your **IMMEDIATE FAMILY**?
[ ] Diabetes [ ] High Blood Pressure [ ] Glaucoma [ ] Macular Degeneration
[ ] Heart Disease [ ] Cancer [ ] Cataracts [ ] None

Social History
D. Do you smoke or have any history of smoking? Yes____ No____ If yes, year started _____
Year quit______
E. Occupation: ______________________ Current place of Employment: ________________________
[ ] Retired [ ] Homemaker [ ] Other
F. Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed
G. Do you have any allergies or adverse reactions to medications?
[ ] Yes [ ] No
____
____
H. Please check **ALL PREVIOUS EYE SURGERIES**
[ ] Cataract [ ] Corneal Transplant [ ] Eye Muscle Surgery [ ] Radial Keratotomy [ ] None
[ ] YAG laser [ ] LASIK/PRK [ ] Trabeculectomy [ ] Other
I. Please check ALL PREVIOUS GENERAL SURGERIES
[ ] Nose Surgery [ ] Tonsils [ ] Ear Surgery/Tubes [ ] Knee Replacement
[ ] Thyroid [ ] Jaw Surgery [ ] Mastectomy [ ] Adenoids
[ ] Breast Biopsy [ ] Hysterectomy [ ] Colon/Bowel Surgery [ ] Back Surgery
[ ] Appendectomy [ ] Hernia [ ] Gallbladder [ ] Other ___________
[ ] Prostate [ ] Bladder Surgery [ ] Hip Replacement [ ] None
[ ] Heart Surgery [ ] Foot Surgery
J. **PLEASE LIST ALL CURRENT EYE MEDICATIONS AND DOSAGES, IF ANY**
[ ] NONE AT IS TIME
____
____
K. **PLEASE LIST OTHER CURRENT MEDICATIONS AND DOSAGES, IF ANY**
____
____

REVIEW OF SYSTEMS

Do you **CURRENTLY** have any of the following symptoms? **PLEASE CHECK ALL THAT APPLY.**

1. **EYES**

[ ] Eye pain [ ] Decreased Vision [ ] Mucous discharge from eyes [ ] Chronic Infections
[ ] Blurred Vision [ ] Itching/Burning [ ] Foreign Body Sensation [ ] Excessive tearing
[ ] Style/Chalazion [ ] Redness [ ] Glare/ Light Sensitivity [ ] Other ___________
[ ] Fluctuate Vision [ ] Tired Eyes [ ] None

2. **EAR, NOSE, MOUTH, & THROAT**

[ ] Hearing Loss [ ] Sinus Problems [ ] Runny Nose [ ] Post Nasal Drip [ ] None
[ ] Dry throat [ ] Dry Mouth [ ] Sore Throat [ ] Other________

3. **CARDIOVASCULAR/HEART**

[ ] Chest pain [ ] Irregular Heart Beat [ ] Other __________ [ ] None

4. **RESPIRATORY/LUNG**

[ ] Shortness of Breath [ ] Chronic Coughs [ ] Wheezing [ ] Bronchitis [ ] Asthma [ ] Other _____ [ ] None

5. **GASTROINTESTINAL**

[ ] Heartburn [ ] Abdominal pain [ ] Diarrhea [ ] Vomiting [ ] Other ________ [ ] None

6. **URINARY**

[ ] Frequent Urination [ ] Pain or Discomfort [ ] Blood in Urine [ ] Other_______ [ ] None

7. **MUSCULOSKELETAL**

[ ] Muscle Aches [ ] Joint Pain [ ] Swollen Joints [ ] Other _______ [ ] None

8. **INTEGUMENTARY/SKIN**

[ ] Rashes [ ] Excessive Dryness [ ] Other ________ [ ] None

9. **NEUROLOGIC**

[ ] Numbness [ ] Weakness [ ] Headaches [ ] Paralysis [ ] None [ ] Other ________

10. **PSYCHIATRIC**

[ ] Depression [ ] Anxiety [ ] Other __________ [ ] None

11. **ENDOCRINE**

[ ] Thyroid Disease [ ] Diabetic [ ] Other __________ [ ] None

12. **HEMATOLOGICAL/LYMPHATIC**

[ ] Anemia [ ] Cancer-Type ___________ [ ] Other _________ [ ] None
Have you ever had a blood transfusion? [ ] Yes [ ] No
Do you have any bleeding or clotting problems? [ ] Yes [ ] No

13. **ALLERGIC/IMMUNOLOGIC**

[ ] Rheumatoid Arthritis [ ] Other _____ [ ] None

14. **CONSTITUTIONAL SYMPTOMS**

[ ] Chronic Fever [ ] Weight loss [ ] Weight gain [ ] Fatigue [ ] None [ ] Other ______

L. Have you ever been exposed to any infectious disease such as Hepatitis, Aids, or Tuberculosis? [ ] Yes [ ] No
If yes, Please explain ____

M. Have you had any prior problems or reactions to local or general anesthesia? [ ] Yes [ ] No
If yes, Please explain ____

SIGNATURE ____________________________________ **DATE:** ___________________________