Patient Medical History Questionnaire

Date _____

Name _____ **Date of Birth** _____

Address _____

City, State, Zip Code _____

Phone Number _____ **2nd Phone Number** _____

Social Security Number _____

Primary Physician: **Name** _____ Phone _____

Address _____

Referring Physician: **Name** _____

Chief Complaint

What is the main thing that is bothering you regarding your eyes? _____

_____

History of Present Illness

How long have you had this problem? _____

Is it getting better, getting worse, or staying the same? _____

What treatments have you tried for this problem? _____

What other eye diseases or surgery have you had? _____

_____

Past Medical History

List diseases for which you are currently being treated or for which you have been treated in the past. _____

_____

_____

List surgical procedures that you have undergone. _____

_____

Current Medications _____

_____

_____

Allergies to Medicines

List all allergies to medications. _____

_____

_____

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Review of Systems

Please check **YES** or **NO** in boxes. If yes, check off symptoms you are experiencing.

Do you currently have:

	YES	NO	EXPLANATION OF PROBLEM
Constitutional Symptoms	☐	☐	(If no, proceed to next topic.)
_____Fever			
_____Weight Loss			
_____Other (specify)			

	YES	NO	
Eye Problems	☐	☐	(If no, proceed to next topic.)
_____Blurry vision			
_____Burning of eyes			
_____Distorted vision			
_____Double vision			
_____Dryness			
_____Excess tearing/watering			
_____Foreign body sensation			
_____Glare/light sensitivity			
_____Itching of eyes			
_____Loss of side vision			
_____Mucous discharge from eyes			
_____Pain or soreness of eyes			
_____Redness of eyes			
_____Sandy or gritty feeling of eyes			
_____Sty			
Difficulty:			
_____Reading small print			
_____Reading road signs			
_____Recognizing faces			
_____Other (specify)			

	YES	NO	
Ear, nose, throat problems	☐	☐	(If no, proceed to next topic.)
_____Ringing in ears			
_____Running ears			
_____Deafness			
_____Balance difficulties			
_____Nosebleeds			
_____Running nose			
_____Frequent sore throats			
_____Hoarseness of voice			
_____Difficulty swallowing			
_____Other (specify)			

	YES	NO	
Dental problems	☐	☐	(If no, proceed to next topic.)
_____Loose teeth			
_____Bleeding gums			
_____Sore tongue			
_____Other (specify)			

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	YES	NO	EXPLANATION OF PROBLEM
Heart problems	☐	☐	(If no, proceed to next topic.)
_____Chest pain on exertion.....			
_____Rapid heart beat.....			
_____Irregular heart beat.....			
_____Inability to lie flat.....			
_____Pounding sensation of heart.....			
_____Other (specify).....			
Blood vessel problems	☐	☐	(If no, proceed to next topic.)
_____Pain in legs when walking.....			
_____Cold stiff hands.....			
_____Blackout spells.....			
_____Other (specify).....			
Respiratory Problems	☐	☐	(If no, proceed to next topic.)
_____Wheezing.....			
_____Coughing up blood.....			
_____Shortness of breath.....			
_____Other (specify).....			
Gastrointestinal problems	☐	☐	(If no, proceed to next topic.)
_____Jaundice.....			
_____Stomach pain.....			
_____Constipation.....			
_____Black stools.....			
_____Frequent diarrhea.....			
_____Other (specify).....			
Genitourinary problems	☐	☐	(If no, proceed to next topic.)
_____Pain on urination.....			
_____Trouble holding your urine.....			
_____Blood in urine.....			
_____Frequent urination.....			
_____Pregnant now.....			
_____Other (specify).....			
Skin or breast problems	☐	☐	(If no, proceed to next topic.)
_____Rashes that do not go away.....			
_____New growth on skin.....			
_____Breast lumps.....			
_____Blood or milk discharge from nipple...			
_____Other (specify).....			
Musculo-Skeletal problems	☐	☐	(If no, proceed to next topic.)
_____Joint swelling.....			
_____Joint pain.....			
_____Inability to make certain movements...			
_____Muscle weakness.....			
_____Other (specify).....			

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	YES	NO	EXPLANATION OF PROBLEM
Neurological problems	☐	☐	(If no, proceed to next topic.)
_____Fainting			
_____Dizziness			
_____Frequent headaches			
_____Convulsions or seizures			
_____Paralysis of any body part			
_____Numbness			
_____Blackout spells			
_____Loss of memory			
_____Other (specify)			

	YES	NO	
Psychiatric problems	☐	☐	(If no, proceed to next topic.)
_____Depression			
_____Mood swings			
_____Panic attacks			
_____Other (specify)			

	YES	NO	
Blood or lymphatic problems	☐	☐	(If no, proceed to next topic.)
_____Easy bruising			
_____Excess bleeding from minor cuts			
_____Lumps in groin, armpit, or neck			
_____Other (specify)			

FOR PHYSICIAN USE ONLY

Reviewed with patient ☐

Recommendations:

_____
Signed

_____
Date