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._____

_____

_____

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)			

	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).....			

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