PATIENT HISTORY QUESTIONAIRE HistQuest2.word 4 13

MEDICAL INFORMATION:
Name of family doctor_____ Date of last physical_____Height_____ Weight ____
Date of last eye exam_____

Do you have any problems with the following systems?

Y N	Y N	Y N
°□° Eyes	°□° Gastrointestinal (Stomach, Intestines)	°□°□ Nervous
°□° Ears/Nose/Throat	°□° Genitourinary(Bladder, Genitals)	° °□ Endocrine(Glands)
°□° Blood/Lymph	°□° Musculoskeletal(Muscle,Bones)	° °□ Respiratory(Lungs)
°□° Integumentary(Skin)	°□° Allergic/Immunologic	° °□ Mental(Psychological)
°□° Cardiovascular(Heart,Blood Vessels)		

Do you have any of the following?
High Blood Pressure Y N Thyroid Disease Y N Headaches Y N
Infectious disease (i.e TB or hepatitis)? Y N Diabetes Y N Date of diagnosis_____
Do you use cigarettes/tobacco? Y N Alcohol? Y N Other substance? Y N
Have you had a blood transfusion? Y N If applicable, are you pregnant or recently pregnant? Y N

Please LIST your OTHER MEDICAL PROBLEMS

_____
_____
_____
_____

Please LIST your MEDICATIONS ○ See attached list

_____
_____
_____
_____

Please list your ALLERGIES to medications ○ See attached list

_____
_____

PERSONAL EYE INFORMATION:

Y N	Y N
° °□Eye operations. Type? _____ Date_____	° °□Macular degeneration
° °□Eye injuries. Type?_____Date_____	° °□Glaucoma
° °□Wear contact lenses. Type?_____	
° °□Other eye problem_____	

FAMILY HISTORY:

Y N	Y N
° °□Macular degeneration. Relation_____	° °□Glaucoma. Relation_____
° °□Diabetes. Relation_____	° °□Other eye condition. Kind? _____

VISUAL NEEDS INFORMATION:
Which of these activities are important to you? □° Reading □° Computer □° Golf □° Fishing □°Driving □° Shooting
□Other_____

Signature_____ **Date**_____

Patient, Parent, or Guardian

UPDATED (Initial and date): _____ _____ _____ _____

Last name_____ **First name**_____ **MI** _____