Health History Questionnaire

Name:			Date:
Date of Birth:	Height:	Weight:	Sex: M / F

Please list any MEDICATIONS/SUPPLEMENTS, otherwise mark ❒ NO MEDICATIONS			
	Name	**Dosage**	**Reason**
1.			
2.			
3.			
4.			
5.			

Please list any DRUG ALLERGIES, otherwise mark ❒ NO KNOWN DRUG ALLERGIES		
	Name	**Please describe the reaction**
1.		
2.		
3.		

Please indicate any OCULAR HISTORY, otherwise mark ❒ NO OCULAR HISTORY	
❒ **Amblyopia** Right/Left	❒ **Retinal Detachment** Right/Left Date:
❒ **Cataract Surgery** Right/Left Date:	❒ **Retinal Laser (in office)** Right/Left Date:
❒ **LASIK** Right/Left Date:	❒ **Retinal Surgery (in OR)** Right/Left Date:
❒ **Glaucoma** Right/Left	❒

Please indicate any MEDICAL CONDITIONS		MEDICAL PROCEDURES
❒ **Anxiety**	❒ **Heart Attack** Date:	❒ **Appendectomy** Date:
❒ **Arthritis**	❒ **Heart Disease**	❒ **Back Surgery** Date:
❒ **Asthma**	❒ **Heart Valve Disorder**	❒ **Cholecystectomy** Date:
❒ **Atrial Fibrillation**	❒ **Hepatitis** Type:	❒ **Colectomy** Date:
❒ **Autoimmune** Type:	❒ **High Blood Pressure**	❒ **Coronary Bypass** Date:
❒ **Blood Clots**	❒ **High Cholesterol**	❒ **Coronary Stent** Date:
❒ **Bronchitis**	❒ **Kidney Disease** ❒ Dialysis	❒ **Hip Replacement** Date:
❒ **Cancer** Type:	❒ **Liver Disease** ❒ Cirrhosis	❒ **Knee Replacement** Date:
❒ **Cardiac Arrhythmia**	❒ **Migraines**	❒ **Pacemaker** Date:
❒ **Congestive Heart Failure**	❒ **Osteoporosis**	❒ **Thyroidectomy** Date:
❒ **COPD/Emphysema**	❒ **Seizures**	❒ **Tonsillectomy** Date:
❒ **Depression**	❒ **Sleep Apnea** ❒ CPAP	❒
❒ **Diabetes** Type:	❒ **Stroke/TIA** Date:	❒
❒ **Gallbladder Disease**	❒ **Thyroid Disease** Type:	❒
❒	❒	❒

Specialists and Other Medical Questions		
❒ **Cardiologist:**	❒ **Endocrinologist:**	❒ **Rheumatologist:**
❒ **Use Portable Oxygen**	❒ **Pregnant**	❒ **Nursing**

Name: Date of Birth:

Please indicate any FAMILY HISTORY, otherwise mark ❒ UNKNOWN FAMILY HISTORY			
❒ **Arthritis**	Relation:	❒ **High Cholesterol**	Relation:
❒ **Asthma**	Relation:	❒ **Kidney Disease**	Relation:
❒ **Blindness**	Relation:	❒ **Macular Degeneration**	Relation:
❒ **Cancer** Type:	Relation:	❒ **Respiratory Disease**	Relation:
❒ **Colitis**	Relation:	❒ **Retinal Detachment**	Relation:
❒ **Corneal Disease**	Relation:	❒ **Seizure Disorder**	Relation:
❒ **Diabetes**	Relation:	❒ **Sjögren's Syndrome**	Relation:
❒ **Glaucoma**	Relation:	❒ **Strabismus**	Relation:
❒ **Heart Disease**	Relation:	❒ **Stroke**	Relation:
❒ **High Blood Pressure**	Relation:	❒ **Thyroid Disorder**	Relation:

SOCIAL HISTORY (please mark Yes or No for each category)			
Have you ever smoked?	Yes / No	How much per day or week?	Current / Quit Year:
Do you drink alcohol?	Yes / No	How much per day or week?	
Do you drink caffeine?	Yes / No	How much per day or week?	
Do you use other drugs?	Yes / No	How much per day or week?	

REVIEW OF SYSTEMS (please mark any symptoms that you are dealing with *currently*)		
Constitutional	**Cardiovascular**	**Dermatologic**
❒ **Fatigue**	❒ **Chest Pressure or Discomfort**	❒ **Dryness**
❒ **Fever**	❒ **Irreg. Heartbeat/Palpitations**	❒ **Open Wound**
❒ **Weight Gain**	**Gastrointestinal**	❒ **Rash**
❒ **Weight Loss**	❒ **Abdominal Pain**	**Musculoskeletal**
Head/Eyes/Ears/Nose/Throat	❒ **Difficulty Swallowing Saliva**	❒ **Back Pain**
❒ **Blurred Vision**	❒ **Heartburn**	❒ **Body Aches**
❒ **Blind Spot or Scotoma**	❒ **Nausea**	❒ **Jaw Pain**
❒ **Eye Pain**	❒ **Reflux**	❒ **Joint Pain**
❒ **Hearing Loss**	❒ **Vomiting**	❒ **Muscle Weakness**
❒ **Floaters**	**Genitourinary**	❒ **Neck Pain**
❒ **Sinus Problems**	❒ **Painful Urination**	**Psychiatric**
❒ **Sore Throat**	❒ **Urgency**	❒ **Depressed Mood**
❒ **Tinnitus or Ringing of Ears**	**Metabolic**	❒ **Hallucinations**
❒ **Vision Changes**	❒ **Cold Intolerance**	❒ **Stress**
❒ **Vision Loss**	❒ **Heat Intolerance**	**Neurologic**
❒ **Visual Disturbance**	**Hematologic**	❒ **Balance Disturbances**
Respiratory	❒ **Bleeding**	❒ **Dizziness**
❒ **Cough**	❒ **Bruising**	❒ **Headache**
❒ **Difficulty Breathing (Resting)**	**Immunologic**	❒ **Memory Difficulty**
❒ **Difficulty Breathing (Exertion)**	❒ **Environmental Allergies**	❒ **Numbness of Extremities**
❒ **Flu-like Symptoms**	❒ **Seasonal Allergies**	❒ **Seizures**