PATIENT MEDICAL QUESTIONNAIRE

Name:_____________________________________ Date of Birth: _________________ Date: _______________

To all patients:

The following questionnaire is intended to help us better evaluate and treat your medical problems. We appreciate you filling it out in its entirety. Should you have any questions about what information to include, please do not hesitate to ask the office staff. Thank you.

1. What is the eye problem that you believe needs to be addressed?

____

____

____

____

2. Do you wear glasses? _____Yes _____No Contact Lenses? _____Yes _____No

   Referring Eye Doctor Name: ____

   Address: ____

   Phone Number: ____

Medications / Dietary / Herbal Supplements?

____

____

____

____

____

List Allergies or Reactions to Medications:

____

____

____

____

____

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PATIENT MEDICAL QUESTIONNAIRE (continued)

Name:_______________________________________

REVIEW OF SYSTEMS:

Do you presently have any problems in the following areas? Check all that apply and provide explanation.

General
_____ Weight loss or gain
_____ Fatigue
_____ Fever or chills
_____ Weakness
_____ Trouble sleeping

Skin
_____ Rashes
_____ Lumps
_____ Itching
_____ Dryness
_____ Color changes
_____ Hair and nail changes

Head
_____ Headaches
_____ Head injury
_____ Neck pain

Ears
_____ Decreased hearing
_____ Ringing in ears
_____ Earache
_____ Drainage

Endocrine
_____ Head or cold intolerance
_____ Sweating
_____ Frequent urination
_____ Thirst
_____ Change in appetite

Throat
_____ Bleeding
_____ Dentures
_____ Sore tongue
_____ Dry mouth
_____ Sore throat
_____ Hoarseness
_____ Thrush
_____ Non-healing sores

Neck
_____ Lumps
_____ Swollen glands
_____ Pain
_____ Stiffness

Breasts
_____ Lumps
_____ Pain
_____ Discharge
_____ Self-exams
_____ Breast feeding

Respiratory
_____ Cough
_____ Sputum
_____ Coughing up blood
_____ Shortness of breath
_____ Wheezing
_____ Painful breathing

Urinary
_____ Frequency
_____ Urgency
_____ Burning or pain
_____ Blood in urine
_____ Incontinence
_____ Change in urinary strength

Vascular
_____ Calf pain with walking
_____ Leg cramping

Musculoskeletal
_____ Muscle or joint pain
_____ Stiffness
_____ Back pain
_____ Redness of joints
_____ Swelling of joints
_____ Trauma

Neurologic
_____ Dizziness
_____ Fainting
_____ Seizures
_____ Weakness
_____ Numbness
_____ Tingling
_____ Tremor

Eyes
_____ Vision Loss / Changes
_____ Glasses or contacts
_____ Pain

Eyes (cont'd)
_____ Redness
_____ Blurry or double vision
_____ Flashing lights
_____ Specks
_____ Glaucoma
_____ Cataracts

Nose
_____ Stuffiness
_____ Discharge
_____ Itching
_____ Hay Fever
_____ Nosebleeds
_____ Sinus pain

Gastrointestinal
_____ Swallowing difficulties
_____ Heartburn
_____ Change in appetite
_____ Nausea
_____ Change in bowel habits
_____ Rectal bleeding
_____ Constipation
_____ Diarrhea
_____ Yellow eyes or skin

Cardiovascular
_____ Chest pain or discomfort
_____ Tightness
_____ Palpitations
_____ Shortness of breath with activity
_____ Difficulty breathing lying down
_____ Swelling
_____ Sudden awakening from sleep with shortness of breath

Hematologic
_____ Ease of bruising
_____ Ease of bleeding

Psychiatric
_____ Nervousness
_____ Stress
_____ Depression
_____ Memory loss

PATIENT MEDICAL QUESTIONNAIRE (continued)

Name:____

EXPLANATION OF SYMPTOMS:

____

____

____

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____

____

PAST MEDICAL HISTORY / CURRENT ILLNESSES (CHECK ALL THAT APPLY):

_____ Anemia
_____ Arthritis
_____ Asthma
_____ Bladder Disease
_____ Bleeding Tendencies
_____ Bronchitis
_____ Cancer
What Type:_________________
_____ Cataracts
_____ Chicken Pox
_____ Dementia (Memory Problems)
_____ Diabetes
_____ Emphysema
_____ Gallbladder Problems
_____ Glaucoma

_____ Heart Disease
_____ Hearing Loss
_____ Hepatitis
☐ A ☐ B ☐ C
_____ High Blood Pressure
_____ HIV
_____ Mental Illness
_____ Influenza
_____ Jaundice
_____ Kidney Failure
_____ Kidney Stones
_____ Measles
_____ Hyperlipidemia
(high cholesterol or triglycerides)
_____ Mumps

_____ Pregnant
Specify Due Date:____________
_____ Reflux
_____ Seizures
_____ Skin Lesions / Rash
_____ Sickle Cell Disease
_____ Stroke
_____ Tuberculosis
_____ Thyroid Disease
_____ Sexually Transmitted Disease
_____ Other
____
____
____

Operations / Hospitalizations: ____

____

____

____

____

Eye Surgery / Laser Treatments (Please indicate eye and date): ______________________________

____

____

____

____

Eye Injection Treatments (include name of drug and indicate eye and date): ____________________

____

____

____

____

PATIENT HABITS:

	Present		Past		Amount
Tobacco (cigarettes, cigars, chewing, pipes)	☐ Y	☐ N	☐ Y	☐ N	__________
Alcohol	☐ Y	☐ N	☐ Y	☐ N	__________
Exercise	☐ Y	☐ N	☐ Y	☐ N	__________
Illicit Drugs	☐ Y	☐ N	☐ Y	☐ N	__________

Type of Drugs: ____

____

FAMILY HISTORY: (check those that a family member has had)

_____ Alzheimer's Disease
_____ ARMD
_____ Asthma
_____ Arthritis
_____ Thyroid Disease
_____ Cancer
_____ Diabetes
_____ Epilepsy
_____ Glaucoma
_____ Other: ______________________________
_____ Heart Problems
_____ High Blood Pressure
_____ Kidney Disease
_____ Retinal Disease

Please provide us with the names of your attending physicians so that we may send them a report of doctor's findings.

Primary Care Physician's Name: ______________________________

Address: ______________________________

____

Phone Number: ______________________________

Cardiologist's Name: ______________________________

Address: ______________________________

____

Phone Number: ______________________________

Endocrinologist's Name: ______________________________

Address: ______________________________

____

Phone Number: ______________________________

Specialist's Name: ______________________________

Address: ______________________________

____

Phone Number: ______________________________

Specialist's Name: ______________________________

Address: ______________________________

____

Phone Number: ______________________________

PHARMACY: ______________________________

Address: ______________________________

____

Phone Number: ______________________________