Health History Questionnaire

Name:_____ **DOB:**___/___/____

*Address :*_____

Phone: _____ *Email:*_____

Reason for visit: _____

_____

Please record any symptoms you may be experiencing or specific concerns that you have about your eyes/ vision:

Have you ever been diagnosed with the following? On an average day, how much are you bothered by the symptoms listed below? (Rate each symptom from 0 to 10, where 10 is the worst it could be, and where 0 means you have none of that symptom)

Dizziness	/10
Nausea	/10
Anxiety	/10
Headache	/10
Neck ache	/10
Unsteady with walking	/10
Sensitivity to light	/10
Reading difficulty	/10

Have you ever been diagnosed with the following?

head injury/ concussion?	Y / N
Lazy eye?	Y / N
Reading difficulty?	Y / N
Have you ever had an operation? If so what was if for:_____	Y / N

(*Check all that apply)*

Have you ever been diagnosed with the following conditions?

Condition	Y	N
Cataracts		
Age-related Macular Degeneration		
Glaucoma		
Diabetes		
Diabetic Retinopathy		
Dry Eye		
Eye Infection, inflammation or allergy		
Floaters and/or flashes of light		
Iritis or Uveitis		
Retinal defects or degenerations		
Lazy eye/ Amblyopia		
Other:		
Double vision		

Review of Systems (please circle those that apply)

Constitutional	Fatigue, weight loss, Cancer
Ear, nose, throat	Hearing loss, sinusitis, dry mouth
Neurological	Multiple Sclerosis, Epilepsy, Cerebral Palsy, Tumor, Migraine, Autism
Psychiatric	Depression, Attention deficit, anxiety disorder, bipolar disorder
Cardiovascular	Hypertension, Stoke/ CVA, heart disease, Vascular disease, Congestive heart failure
Respiratory	Asthma, bronchitis, Emphysema, Chronic Obstruction, Sleep apnea
Gastrointestinal	Crohn's disease, colitis, ulcer, acid reflux, celiac disease
Genitourinary	Kidney disease, Prostate disease/cancer, STD, Pregnant, nursing
Musculoskeletal	Arthritis, Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis, Osteoporosis, Gout
Integumentary	Eczema, Rosascea, Psoriasis, Herpes Simplex, Herpes Zoster/Shingles
Endocrine	Type 2 Diabetes Mellitus, Type 1 Diabetes Mellitus, Thyroid, Hormonal dysfunction
Heme/ Lymph	Anemia, Hypercholesteremia
Allergy/Immune	Environmental allergies, Rheumatoid Arthritis, Lupus, Sjogren's syndrome
Other	

Please list all medications: (oral and/or eye drops)

Medication	**Dosage**	**For**

Allergies to medication

Social History

Current Occupation:
Hobbies:
Do you drink? Y / N If yes how much? ___/ wk
Do you smoke? Y / N If yes how much? ___/ day
Former smoker? Y/ N

Family History

Condition	Y	N	Who
Cancer type:			
Diabetes Mellitus			
Hypertension			
Hyperthyroid			
Hypothyroid			
Cataracts			
Macular Degeneration			
Glaucoma			