PATIENT HEALTH HISTORY QUESTIONAIRE

IMPORTANT: Complete this form to the best of your abilities and review and correct any changes before each and every exam

PATIENT INFORMATION:		
LAST NAME	**FIRST NAME**	**DATE OF BIRTH**

CHIEF COMPLAINT: (Why you are here today)

DO YOU OR HAVE YOU WORN EYEGLASSES?	**YES**	**NO**	HOW LONG:
DO YOU OR HAVE YOU WORN CONTACT LENSES?	**YES**	**NO**	TYPE & HOW LONG:
HAVE YOU EVER HAD ANY TYPE OF EYE SURGERY?	**YES**	**NO**	DATE, TYPE, &DR.:

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

BLURRED VISION…….. YES NO
PAIN IN OR AROUND EYES…….. YES NO
FLASHES OR FLOATERS…….. YES NO
HEADACHES…… YES NO
DRY EYES…… YES NO

OTHER COMPLAINTS?

LOCATION OF PROBLEM:_____
SIGNS & SYMPTOMS:_____
SEVERITY: LOW 1 2 3 4 5 6 7 8 9 10 HIGH
HOW OFTEN DOES THIS HAPPEN:_____
DURRATION: _____
MODDIFYING FACTORS: _____

SIMILAR FAMILY OR PERSONAL OCCURRENCES IN PAST:

OCCUPATION OF SOCIAL HISTORY RELATING TO CONDITION:

MEDICATIONS & ALLERGIES:

PLEASE LIST ANY MEDICATIONS BOTH PERSCRIPTION & NON-PERSCRIPTION THAT YOU TAKE

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS: YES NO *IF YES, PLEASE LIST:*

DO YOU HAVE ANY OTHER ALLERGIES: YES NO *IF YES, PLEASE LIST:*

MEDICAL HISTORY:

NAME OF FAMILY DOCTOR: **DATE OF LAST VISIT:**

WHEN YOUR LAST TETANUS SHOT RECIVED? **DATE:** ☐ *I Don't Know/Remember*

DO YOU USE CIGARETTES OR TOBACCO?	**YES**	**NO**	AMOUNT USED:
DO YOU USE ALCOHOL	**YES**	**NO**	AMOUNT USED:
DO YOU USE ANY RECREATIONAL DRUGS	**YES**	**NO**	TYPE &AMOUNT USED:

DO YOU HAVE ANY PROBLEMS WITH OR TAKE ANY MEDICATIONS FOR THE FOLLOWING ORGAN SYSTEMS?
(If yes, please list condition and any medication taken for condition)

ALLERGIC / IMMUNOLOGIC	**YES**	**NO**	GASTROINTESTINAL	**YES**	**NO**
BLOOD / LYMPHATIC	**YES**	**NO**	GENITOURINARY (*Urinary*)	**YES**	**NO**
CARDIOVASCULAR	**YES**	**NO**	INTEGUMENTARY (*Skin*)	**YES**	**NO**
CONSTITUTIONAL (Fever, Weight Loss)	**YES**	**NO**	MUSCLES / BONES	**YES**	**NO**
EYES	**YES**	**NO**	NEUROLOGICAL	**YES**	**NO**
EARS, NOSE, MOUTH, THROAT	**YES**	**NO**	PSYCHIATRIC	**YES**	**NO**
ENDOCRINE (Thyroid/Glands)	**YES**	**NO**	OTHER:	**YES**	**NO**

DO YOU OR ANY FAMILY MEMBERS HAVE ANY KNOWN HISTORY OF THE FOLLOWING:
(If yes, please circle self if yourself and or persons relationship to you)

DIABETES	**YES**	**NO**	*Self*	*Mom*	*Dad*	*Grandma*	*Grandpa*	**CATARACTS**	**YES**	**NO**	*Self*	*Mom*	*Dad*	*Grandma*	*Grandpa*
HIGH BLOOD PREASURE	**YES**	**NO**	*Self*	*Mom*	*Dad*	*Grandma*	*Grandpa*	**BLINDNESS**	**YES**	**NO**	*Self*	*Mom*	*Dad*	*Grandma*	*Grandpa*
GLAUCOMA	**YES**	**NO**	*Self*	*Mom*	*Dad*	*Grandma*	*Grandpa*	**RETINAL DETACHMENT**	**YES**	**NO**	*Self*	*Mom*	*Dad*	*Grandma*	*Grandpa*
MACULAR DEGENERATION	**YES**	**NO**	*Self*	*Mom*	*Dad*	*Grandma*	*Grandpa*	**OTHER EYE CONDITIONS**	**YES**	**NO**	(*Please explain below*)				

I HAVE REVIEWED THE ABOVE INFORMATION AND VERIFY THAT IT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

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SIGNATURE:_____DATE:_____