New Patient Medical Health History Questionnaire

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_ Age\_\_\_\_ Today's Date\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician name/clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ph. Number\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical and Surgical History** -Do you have a history of any of the following conditions?

|  |  |  |  |
| --- | --- | --- | --- |
| **Allergic/Immunologic** □ Environmental allergies □ Seasonal allergies □ Lupus □ Rheumatoid arthritis □ Ankylosing spondylitis  | **Cardiovascular** □ Atrial fibrillation □ Coronary artery disease □ Hypertension □ Stroke  | **Respiratory** □ Asthma □ COPD □ Bronchitis □ Emphysema  | **Ears/Nose/Throat** □ Hearing loss □ Sinus problems □ Vertigo  |
| **Endocrine** □ Diabetes □ Thyroid disease□ Hormone replacement  | **Skin** □ Eczema □ Rosacea □ Psoriasis □ Acne | **Genitourinary** □ BPH □ End stage renal disease □ Hepatitis □ Herpes □ Chlamydia  | **Neurological** □ Multiple sclerosis □ Epilepsy/Seizures □ Headaches □ Migraines  |
| **Psychiatric** □ Anxiety □ Depression  | **Constitutional** □ Unexplained weight loss □ Unexplained weight gain □ Sleep apnea | **Gastrointestinal** □ GERD □ Crohn's □ Colitis  | **Hematologic** □ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Anemia  |
| **Musculoskeletal** □ Arthritis □ Bone marrow transplant □ Fibromyalgia □ Muscular dystrophy  | **Other diseases:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Past surgeries:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Past surgeries:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Past Ocular History**

Do you wear eyeglasses? □ Yes □ No    For what activities? (□ Full Time)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contact lenses? □ Yes □ No What type are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a history of?**

□ Dry Eyes     □ Flashes     □ Glaucoma     □ Cataracts     □ Fluctuating Vision     □ Macular Degeneration

□ Strabismus  □ Floaters    □ Retinal Detachment/Tear    □ LASIK/PRK    □ RK  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all** **current medications: Please list all allergies:**

 **□ None □ None**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Social History:**

**Smoking Status:** □ Never □ Every day □ Some days □ Former □ Heavy □ Light □ Unknown

**Do you drink alcohol?**□ None □ Less than 1 drink per day □ 1-2 drinks per day □ 3 or more drinks per day

**Family History:**

Do you have a family history of any of the following conditions? Please list relation:

|  |  |  |
| --- | --- | --- |
| □ Glaucoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | □ Crossed/lazy eye \_\_\_\_\_\_\_\_\_\_\_\_  | □ Heart disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| □ Cataract \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | □ Blindness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | □ Hypertension \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| □ Macular degeneration \_\_\_\_\_\_\_\_\_\_ | □ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | □ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**Review of Systems:**

Do you currently have any of the following symptoms?

|  |  |  |  |
| --- | --- | --- | --- |
| **Constitutional** □ Fatigue □ Fever □ Weight loss  | **Allergic/Immunologic** □ Seasonal allergies □ Environmental allergies □ Dry mouth | **Endocrine** □ Cold intolerance □ Heat intolerance □ Always thirsty □ Frequent urination  | **Integumentary** □ Rash □ Skin sores   |
| **HEENT** □ Sinus problems □ Upper respiratory infection □ Vertigo  | **Gastrointestinal** □ Abdominal pain □ Jaundice □ Nausea □ Diarrhea  | **Neurological** □ Weakness □ Headache □ Memory difficulty □ Numbness of extremities  | **Musculoskeletal** □ Back/neck pain□ Fracture □ Joint swelling □ Muscle weakness  |
| **Respiratory** □ Cough □ Shortness of breath □ Bronchitis  | **Genitourinary** □ Painful urination □ Genital lesions □ Urethral discharge  | **Psychiatric** □ Depressed mood □ Hallucinations □ Nervousness  | **Hematologic/Lymphatic** □ Bleeding □ Bruising  |

**Name (please print)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred method of contact: □ Phone □ Text □ Email

Please provide preferred number/email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**May we leave a detailed message?** □ **Yes** □ **No**