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**