

# 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?

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

**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:**

None

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

**Please list all allergies:**

None

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

**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:

<input type="checkbox"/> Glaucoma _____	<input type="checkbox"/> Crossed/lazy eye _____	<input type="checkbox"/> Heart disease _____
<input type="checkbox"/> Cataract _____	<input type="checkbox"/> Blindness _____	<input type="checkbox"/> Hypertension _____
<input type="checkbox"/> Macular degeneration _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Cancer _____

**Review of Systems:**

Do you currently have any of the following symptoms?

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

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

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

**Name of persons other than yourself who may have access to your medical and financial records?**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Preferred method of contact:     Phone             Text             Email

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

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