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:

□ **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:

□ 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 _____

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