Current Health History Questionnaire

Do you have any <u>general medical problems</u> or <u>changes in overall health</u> that you would like to bring to the Doctor's attention today? Example: changes in blood pressure, blood glucose control, recent illnesses, hospitalization, etc. <u>Please List and Explain</u>

Medications Please list all **<u>current</u>** medications **Medication Allergies**

Eye Surgeries Please note **<u>type</u>** and **<u>date</u>** of surgery

Other Surgeries Please note **<u>type</u>** and **<u>date</u>** of surgery

Patient Health History

Patient Name: _____ Date: _____

Occupation:_____ Hobbies: _____

Chronic Illnesses: Please mark all **CURRENT** and **PAST** Conditions

Eyes

- ☐ Glaucoma
- ☐ Retinal Disease
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Iritis
- ☐ Eye Injury
- ☐ Crossed Eyes
- ☐ Corneal Disease
- ☐ Any Other Eye Disorder?

Ear, Nose, and Throat

- ☐ Vertigo
- ☐ Sinusitis

Cardiovascular

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Carotid Artery Disease

Respiratory

- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ COPD

Gastrointestinal

- ☐ Hepatitis
- ☐ Ulcer
- ☐ Gallbladder

Genitourinary

- ☐ Kidney Disease
- ☐ Prostate Disorder

Muscles/Skeletal

- ☐ Osteoarthritis
- ☐ Gout

Integumentary (Skin)

- ☐ Psoriasis / Eczema
- ☐ Skin Cancer

Neurologic

- ☐ Stroke
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Migraines

Psychiatric

- ☐ Bipolar
- ☐ Alzheimer's

Endocrine

- ☐ Diabetes
- ☐ Thyroid Dysfunction

Hematologic/Lymphatic

- ☐ Anemia
- ☐ Other Blood Disorder

Allergy/Immune

- ☐ Rheumatoid Arthritis
- ☐ Sarcoid
- ☐ Lupus
- ☐ Leukemia
- ☐ HIV / AIDS
- ☐ Other: (Explain)

Family History (Has anyone in your family (blood relative) had any of the following?)

Note Relation to Patient using Abbreviation: F=Father, M=Mother, S=Sister, B=Brother, U=Uncle, A=Aunt, P=Paternal, M=Maternal, GF=Grandfather, GM=Grandmother

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Corneal Disease
- ☐ Macular Degeneration
- ☐ Retinal Disease
- ☐ Crossed Eyes
- ☐ Amblyopia or "Lazy Eye"
- ☐ Any Other Eye Disorder
- ☐ Diabetes
- ☐ Heart Condition
- ☐ Stroke
- ☐ Other General Health Problems (Explain)

Social History Please mark all that apply

- ☐ Do you smoke? __ Packs per day? __ Packs per week?
- ☐ Do you drink alcohol? __ # per day? __ # per month?
- ☐ Do you use recreational drugs? ☐ (Women) Are you Pregnant or Nursing?
- ☐ Single? ☐ Married? spouse's name ☐ Widowed? ☐ I live alone

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