## PATIENT HEALTH HISTORY QUESTIONNAIRE

Please answer all questions.

NAME: _____ Today's Date: _____

AGE: _____ DATE OF BIRTH: _____

### MEDICAL INFORMATION

Do you have problems with any of these systems? (Please **circle yes or no.**)

| | | Pregnant/Nursing | Yes/No |
|---|---|---|---|
| DIABETES | Yes / No | GASTROINTESTINAL | Yes / No |
| HIGH BLOOD PRESSURE | Yes / No | EARS/NOSE/THROAT | Yes / No |
| HEART DISEASE | Yes / No | CARDIOVASCULAR | Yes / No |
| ARTHRITIS | Yes / No | RESPIRTORY | Yes / No |
| CANCER | Yes / No | GENITOURINARY | Yes / No |
| DERMATOLOGIC | Yes / No | KIDNEY STONES | Yes / No |
| STEROID USE | Yes / No | BLOOD/LYMPH | Yes / No |
| HEADACHES | Yes / No | OTHER ILLNESS | Yes / No |

Allergies to Medications: Yes / No Please List: _____

_____

Current medications please List: _____

_____

Eye Medications: _____

Do you use Alcohol? Yes / No How much in one week? _____

Do you use Tobacco? Yes / No How much in one week? _____

### FAMILY HISTORY

| | | |
|---|---|---|
| High blood pressure | Yes / No | Relation_____ |
| Diabetes | Yes / No | Relation_____ |
| Macular degeneration | Yes / No | Relation_____ |
| Glaucoma | Yes / No | Relation_____ |
| Retinal detachment | Yes / No | Relation_____ |
| Cataracts | Yes / No | Relation_____ |
| Blindness | Yes / No | Relation_____ |
| Other | Yes / No | Relation_____ |

### PERSONAL EYE HISTORY

Have you had any eye injury? Yes / No What Kind?_____ Date_____

Have you had any eye operations? Yes/No What Kind? _____ Date_____

**(Please circle.)**

Do you have Glaucoma? Cataracts? Retinal detachment? Macular degeneration?

Dry Eyes? Blurred Vision? Lazy Eye/Crossed Eye

Do you wear glasses? Yes/No Do you wear Contacts? Yes/No

**UPDATED** _____

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