Patient History Questionnaire

Highland Retina Associates LLC

Patient Name: _____ Today's Date: _____

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

Reason for visit:

Previous eye conditions and surgeries:

Current Eye Drops/ Frequency:

Medical:

____ **No Medical History**

Influenza vaccine received Yes No

Pneumonia vaccine received Yes No

Allergies: Chronic Seasonal

Alzheimer's/ Dementia

Anemia/Bleeding disorder

Arthritis / Rheumatoid

Cancer: _____

Chest Pains

COPD

Diabetes: Type 1 Type 2 Gestational

Hemoglobin A1C level _____

Heart Attack

Heart Condition: _____

Heart Disease/Vascular disease

Hepatitis: A B C

Herpes Virus: Cold Sores/ Shingles

High Cholesterol

High Blood Pressure

HIV/AIDS

Kidney Disease/ Dialysis/ Failure

Liver Disease

Long Term/ Current Steroid Use

Lung Disease/ TB

Lupus

Melanoma

Meningitis

Migraine

Multiple Sclerosis

Pneumonia

Pregnant

Psychiatric Disorder

Recent Chemotherapy Treatment

Recent fall

Radiotherapy Treatment

Seizures

Sickle Cell

Sleep Apnea

Stroke/TIA (Transient Ischemic Attack)

Syphilis

Temporal Arteritis/ Polymyalgia Rheumatica

Terminal Illness: _____

Thyroid Disease

Other _____

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<u>Surgical</u>: (please list dates of surgeries)

___ **No Surgical History**

Amputation

Angioplasty

Back Surgery

Blood Transfusion

CABG/ Bypass surgery

Defibrillator/ Pacemaker

Gastric Bypass

Heart Stent

Mastectomy

Thyroidectomy

Transplant:

Other_____

Head/ Body Trauma: ***Date:*** _____

Ocular Trauma: ***Date:*** _____

Please list ALL of your current medications, or provide front office with an updated list

Name/dose/frequency/route

_____

_____

_____

_____

_____

_____

_____

_____

Please list your ALLERGIES if any:

_____

_____

_____

<u>FAMILY HISTORY:</u>

Any relative with eye or medical conditions/ if yes please note relationship to patient

DIABETES

CANCER

STROKE / HEART DISEASE

GLAUCOMA

MACULAR DEGENERATION

RETINAL DETACHMENT

CATARACTS

ARTHRITIS/ AUTOIMMUNE DISEASE

KIDNEY DIESEASE

THYROID DISEASE

OTHER

SOCIAL HISTORY:

Marital Status:

Smoking/Tobacco status
Daily Occasional Former Never

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Alcohol status:
Daily Occasional Former Never

Street drugs:
No Yes:_____

Living conditions: □ alone/ □ nursing home/
□ with family or other_____

Do you reside in Skilled Nursing
Facility/Assisted living? Yes No

Do you drive? Yes No

REVIEW OF SYSTEMS: Please circle and explain.

♦ALLERGY/IMMUNOLOGY:

None
Autoimmune
Seasonal / Drug allergies
Recurrent infections

♦CARDIOVASCULAR:

None
Chest Pain
Shortness of Breath
Irregular Heart Beat/ Heart Palpitations
High Blood Pressure
Swelling of Extremities

♦CONSTITUTIONAL:

None
Intolerance to cold/heat
Hair Loss
Nervousness
Fever Chills
Weight Loss Loss of Appetite
Fatigue
Feels Sick/ Weak

♦ENDOCRINE:

None
Excessive Thirst
Excessive Urination
Intolerance of Cold / Heat
Hair Loss
Unstable blood sugar
Sarcoidosis

♦GASTROINTESTINAL:

None
Abdominal Pain
Nausea Vomiting Diarrhea
Bloody Stool
Stomach Ulcer
Trouble Swallowing

♦GENITOURINARY:

None
Urinary problems: _____
Kidney Stones

♦HEMATOLOGY/ONCOLOGY:

None
Easy Bruising

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Prolonged Bleeding
Swollen Lymph Nodes

♦HEAD/EARS/NOSE/THROAT:

None
Hearing Loss/ Ringing
Sore Throat/ Difficulty Swallowing
Runny Nose/ Congestion/ Nose bleeds
Dry Mouth
Jaw Claudication
Ear Ache
Stiff Neck/ Neck Pain

♦SKIN (INTEGUMENTARY)

None
Rash
Change in Mole
Skin Sores
Nail Changes

♦MUSCULOSKELETAL:

None
Muscle Aches
Joint Pain/ Swelling
Back Pain

♦NERUOLOGIC:

None
Weakness/ Numbness/ Tingling
Headaches
Scalp Tenderness
Dizziness/ Vertigo
Paralysis of Extremities
Tremor
Difficulty walking
Seizures or Convulsions
Fainting

♦PSYCHIATRIC:

None
ADHD
Bipolar Disorder
Depression Anxiety
Panic Attack
Hallucinations/ Schizophrenia

♦RESPIRATORY:

None
Wheezing
Coughing (Productive/ Bloody)
Severe or Frequent Colds
Difficulty Breathing/ Asthma

Please list any other issues you think we may need to know:

_____

_____

THANK YOU. THIS INFORMATION IS CRUCIAL IN THE TREATMENT OF YOUR EYE CONDITION.