OcuSight Eye Care Center

Patient History Questionnaire

Patient Name: _____

Review of Systems: Please indicate **YES** if applicable and explain. Be sure to list any surgeries you have had. **PLEASE COMPLETE BOTH SIDES OF THIS QUESTIONNAIRE.**

EYES	**YES**	
Chronic Infection	_____	_____
Double Vision	_____	_____
Dryness	_____	_____
Itching	_____	_____
Loss of Vision	_____	_____
Mucous Discharge	_____	_____
Pain or Redness	_____	_____
Stye or Chalazion	_____	_____
Visual Acuity Fluctuation	_____	_____
Other	_____	_____
Cardiovascular		
Congestive Heart Failure	_____	_____
Heart Attack	_____	_____
Blood Pressure Problem	_____	_____
Chest Pain/Angina	_____	_____
Other	_____	_____
Allergic/Immunologic		
Seasonal Allergies	_____	_____
Hay Fever	_____	_____
Other	_____	_____
Endocrine		
Diabetes	_____	_____
Thyroid Problems	_____	_____
Lupus	_____	_____
Other	_____	_____
Neurological		
Fainting/Dizziness	_____	_____
Migraines	_____	_____
Seizures/Epilepsy	_____	_____
Stroke/Epilepsy	_____	_____
Alzheimer's	_____	_____
Benign Tumor	_____	_____
Other	_____	_____
Ear, Nose, Throat		
Sinus Congestion	_____	_____
Hearing Problems	_____	_____
Chronic Cough	_____	_____
Dry Throat/Mouth	_____	_____
Other	_____	_____
Respiratory		
Asthma	_____	_____
Emphysema	_____	_____
Tuberculosis	_____	_____
Lung Cancer	_____	_____
Sarcoidosis	_____	_____
Other	_____	_____

Gastrointestinal (Stomach/Intestines) **YES**

Jaundice/Hepatitis	_____	_____
Ulcers/Bleeding	_____	_____
Hiatal Hernia	_____	_____
Cancer	_____	_____
Other	_____	_____

Genitourinary (Kidney, Bladder)

Kidney Disease	_____	_____
Prostrate Cancer	_____	_____
Cervical, Ovarian Cancer	_____	_____
Other	_____	_____

Integumentary (Skin/Breast)

Skin Disease/Cancer	_____	_____
Breast Disease/Cancer	_____	_____
Other	_____	_____

Musculoskeletal

Degenerative Arthritis	_____	_____
Rheumatoid Arthritis	_____	_____
Weight Loss/Gain	_____	_____
Cancer	_____	_____
Other	_____	_____

Hematologic/Lymphatic

Anemia	_____	_____
Sickle Cell Disease	_____	_____
Leukemia	_____	_____
Swelling	_____	_____

Family History: Do any of your blood relative have any of the following:

	YES	**Relationship**		**YES**	**Relationship**
Blindness	___	_____	Cancer	___	_____
Cataract	___	_____	Arthritis	___	_____
Glaucoma	___	_____	Diabetes	___	_____
Retina Problems	___	_____	Heart	___	_____
Eye Muscle	___	_____	Thyroid	___	_____
Macular Degen.	___	_____	Blood		
Other	___	_____	Pressure	___	_____

Are you allergic to any Medications?
If YES please list _____
_____
_____

List ALL Medications you are currently using
_____
_____
_____

Are you allergic to Latex ____YES

Social History:

Marital Status: ___Single ___Married ___Widowed ___Divorced
Do you Smoke? ___Yes ___No If yes how much? _____
Do you Drink Alcohol? __Yes __No If yes how much? _____

Date _____ Patient's Signature _____
(Parent or Guardian, if minor)