HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*			☐ M ☐ F			**DOB:**	
Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed	
Previous or referring doctor:			**Date of last eye exam:**				

OCULAR HISTORY

Do you wear: ☐ None ☐ Glasses ☐ Contact Lenses ☐ Glasses and Contact Lenses	
PLEASE MARK ANY CONDITION YOU HAVE PRESENTLY OR HAVE HAD IN THE PAST	
☐ Dry Eyes	☐ Macular Degeneration
☐ Glaucoma	☐ Retinal Detachment
☐ Cataracts	☐ Keratoconus
☐ Other:	

PLEASE MARK ANY CONDITION YOUR FAMILY MEMBER OR BLOOD RELATIVE HAVE PRESENTLY OR HAVE HAD IN THE PAST		
Condition	**Relationship**	**Description**
Cataracts		
Dry Eyes		
Glaucoma		
Keratoconus		
Macular Degeneration		
Retinal Detachment		
Others:		

GENERAL HEALTH

PRIMARY CARE PHYSICIAN				**ADVANCE DIRECTIVE (No/Living Will/Power of Attorney/Other)**
BLOOD SUGAR				
Date:	**Blood Sugar: (mg/dl)**	**HbA1c:**	**Fasting:**	
Time of day:		**Description:**		
CHOLESTEROL				
Date:	**Total:**	**Trig:**	**LDL:**	**HDL:**
Description:				

MEDICAL CONDITIONS

Please mark any condition you have presently or have had in the past	
☐ No known patient medical condition	
DISEASES	**DESCRIPTION**
☐ High Blood Pressure	
☐ Heart Problem	
☐ Arthritis ☐ RA ☐ OA	
☐ Lung problem	
☐ Stroke	
☐ Thyroid Problems	
☐ Diabetes_____ (Diet/NIDDM/IDDM)	
☐ Muscles, Bones, Joints	
☐ LDL	

HEALTH HISTORY QUESTIONNAIRE CONTINUED Pg. 3

☐ Colorectal cancer screenings	☐ High Risk for cardiac events on aspirin prophylaxis		☐ Counseling for Nutrition/Diet	☐ Flu Vaccine
☐ Pneumococcal Vaccine	☐ Risk Assessment	☐ Mammogram	☐ Counseling for Physical Activity	Other:

☐ **No known medical condition**						
Allergic / Immunologic & Blood / Lymphatic	☐ Seasonal Allergies			☐ Hay Fever	☐ OTHERS	
Genitourinary	☐ Genital Ulcers	☐ Discharge	☐ Kidney Stones	☐ Blood in Urine	☐ OTHERS	
Cardiovascular	☐ Chest Pain		☐ Congestive Heart Failure	☐ Irregular Rhythm	☐ OTHERS	
Head / Neck	☐ Sinus Problems	☐ Post Nasal Drip	☐ Runny Nose	☐ Hay Fever	☐ Hearing Loss	☐ OTHERS
Constitutional & Integumentary (Skin)	☐ Fever	☐ Weight Loss	☐ Rash	☐ Skin Disease	☐ OTHERS	
Neurological Psychiatry & Musculoskeletal	☐ Headache	☐ Migraines	☐ Joint Ache	☐ Paralysis Fever	☐ OTHERS	
Gastrointestinal	☐ Negative		☐ Seasonal Allergies	☐ Hay Fever	☐ OTHERS	
Neurological Psychiatry & Musculoskeletal	☐ Cough	☐ Bronchitis	☐ Shortness of Breath	☐ Asthma	☐ Emphysema	☐ COPD	☐ OTHERS

Do you smoke?			
If yes, how often? Occasionally		☐ ½ pack per day	☐ 1+ pack per day
Is there any family history of smoking? ☐ Yes ☐ No		Relationship:	
Do you drink alcohol?		☐ Yes	☐ No
If yes, how often? Occasionally		☐ 1-3 per day	☐ 4+ per day
Is there any family history of alcohol? ☐ Yes ☐ No		Relationship:	

Was patient a full term 40 week pregnancy?	☐ Yes	☐ No	
If no, how many weeks was the pregnancy?			
What was the patient's birth weight?	lbs	oz	
Was it a normal delivery?	☐ Yes	☐ No	
i) C-Sections	☐ Yes	☐ No	
ii) Forceps	☐ Yes	☐ No	

HEALTH HISTORY QUESTIONNAIRE CONTINUED Pg. 4

a) If yes, for how long?			
Does or has the patient participated in occupational, speech, physical, or other therapy?	☐ Yes	☐ No	
If so specify:			
Has the patient ever been admitted to the hospital?	☐ Yes	☐ No	

List any prescribed medications or over-the-counter drugs, such as vitamins and inhalers			
Name of Medication	Strength	Frequency Taken	Prescribing Physician
List any food allergies and/or allergies to medications			
Name of Allergy/Medication	Reaction You Had		

Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

History Reviewed _____ No Changes _____ Additions as noted above _____

Physician's Signature _____