WILLIAMSON ALLEMOND
REGIONAL EYE CENTER

Patient History Questionnaire

Name: _____ Date: _____

MEDICAL HISTORY Date of last exam: _____

REVIEW OF SYSTEMS: Check all that apply.

Allergic / Immunologic: ❒ Hay fever ❒ Food ❒ Medication

Cardiovascular/Cardiac: ❒ High blood pressure ❒ Heart Disease

Constitutional Symptoms: ❒ Recent fever ❒ Weight loss ❒ Weight gain

Ears, Nose, Mouth & Throat: ❒ Chronic cough ❒ Sore Throat ❒ Sinus

Endocrine: ❒ Diabetes ❒ Thyroid ❒ Other: _____

Hematologic/Lymphatic: ❒ Swelling of glands ❒ Coumadin

Integumentary: ❒ Lesions ❒ Rashes ❒ Other: _____

Musculoskeletal: ❒ Arthritis ❒ Plaquenil User ❒ Osteoporosis

Neurological: ❒ Dizziness ❒ Pain ❒ Headaches ❒ Memory loss ❒ Stroke

Respiratory: ❒ Lungs ❒ Breathing ❒ Bronchitis ❒ Other: _____

Any Prior Surgeries: _____

Eye disease, infection, injury, contacts: _____

_____

1. Have you experienced any of the followoing symptoms? Yes or No (If yes please explain)

Change in vision (distant or near)
❒ Yes ❒ No _____

Spider Web / floaters / flashes
❒ Yes ❒ No _____

Blurry, Cloudy, / Poor Night Vision
❒ Yes ❒ No _____

Sensitive to light
❒ Yes ❒ No _____

Double Vision
❒ Yes ❒ No _____

Pain in the eye
❒ Yes ❒ No _____

Distorted Vision
❒ Yes ❒ No _____

Chalazion / Stye
❒ Yes ❒ No _____

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Rainbows / Halos
❒ Yes ❒ No _____

Redness, Discharge
❒ Yes ❒ No _____

Loss of Vision
❒ Yes ❒ No _____

Dry, Itchy Eye, Tearing
❒ Yes ❒ No _____

Crossed Eye / Lazy Eye
❒ Yes ❒ No _____

Headaches
❒ Yes ❒ No _____

FAMILY HISTORY

Disease	Yes	No	Relationship to patient		Yes	No	Relationship to patient
Blindness	❒	❒	_____	Arthritis	❒	❒	_____
Cataract	❒	❒	_____	Cancer	❒	❒	_____
Glaucoma	❒	❒	_____	Diabetes	❒	❒	_____
Macular degeneration	❒	❒	_____	Heart attack	❒	❒	_____
Retinal detachment	❒	❒	_____	High Blood pressure	❒	❒	_____
Stroke	❒	❒	_____	Lupus	❒	❒	_____
Sjogren's syndrome	❒	❒	_____	Thyroid disease	❒	❒	_____
Tuberculosis	❒	❒	_____	Other	❒	❒	_____

SOCIAL HISTORY

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Other
Current Occupation: _____
Do you drink alcohol? ❒ Yes ❒ No If yes, how often? _____
Do you smoke? ❒ Yes ❒ No If yes, how many packs a day? _____
Have you ever had a blood transfusion? ❒ Yes ❒ No If yes, When? _____
Please list current medications: _____

Reason for this visit: _____
_____