

PATIENT QUESTIONNAIRE

NAME:	D.O.B.:
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Medical history review:

MEDICATION	Used for:

MEDICATION	Used for:

I am allergic to: _____

System	No	Comments
Central Nervous System/Skeletal <input type="checkbox"/> Stroke <input type="checkbox"/> Seizure <input type="checkbox"/> Arthritis <input type="checkbox"/> Migraines <input type="checkbox"/> M.S. <input type="checkbox"/> Parkinson's <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia <input type="checkbox"/> Other		
Cardiovascular <input type="checkbox"/> Hypertension <input type="checkbox"/> Angina <input type="checkbox"/> Heart Attack <input type="checkbox"/> CHF <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Pacemaker <input type="checkbox"/> ICD <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Other		
Gastrointestinal <input type="checkbox"/> Ulcers <input type="checkbox"/> Hiatal hernia/Reflux <input type="checkbox"/> Other		
Hematologic <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Tendency <input type="checkbox"/> Other		
Autoimmune Disorders <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Grave's Disease <input type="checkbox"/> Hashimoto's Thyroiditis <input type="checkbox"/> Sjogren's <input type="checkbox"/> Crohn's <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Polymyalgia <input type="checkbox"/> Other		
Miscellaneous <input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Allergies <input type="checkbox"/> Sinus <input type="checkbox"/> Hepatitis <input type="checkbox"/> Enlarged Prostate <input type="checkbox"/> Mersa <input type="checkbox"/> HIV <input type="checkbox"/> Other		
FAMILY OCULAR HISTORY <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Retinal detachment <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Diabetic		

Have you ever been diagnosed with cancer? No Yes, please specify _____

Do you wear a hearing aid? No Yes

Recent surgeries: _____

Social history review:

Smoking: I have never smoked. I am a former smoker. I smoke currently.

Alcohol: Number of drink(s) _____ per _____

Primary care physician: _____ Phone # _____

INFORMATION OBTAINED FROM: Patient Spouse Parent Other

SIGNATURE: _____ DATE: _____

Emergency Contact: _____ Phone: _____