Patient History Questionnaire

CMS Update 2013

Name: ____ Date: __________

(Gov't use: Race:_____ Ethnicity ________ Preferred Language _______ Ht______ Wt____Sex: M/F)

Systemic Medical History

Name of family doctor ________________________________ Date of last visit________________

List any **current systemic medications** and **reasons for each**:________________________________

____

____

____

List any **medication allergies and what happens for each**: ________________________________

____

List any recent operations: ____

Pharmacy Name and address if known____

Ocular History

Approximate date of last dilated eye exam _________ Doctor ________________________

Circle which you have: Blurred vision Cataracts Dry Eyes Eye allergies Flashes Floaters Macular Degeneration Glaucoma Other:________________________________

____

List any current eye medications you take: ____

List any eye surgeries, infections, or injuries: ____________________________________

____

Social History

Complete if use: Cigarettes/tobacco__ How Much_______ Alcohol__ Frequency_____ Dependence Y / N

Past cigarette/tobacco use_____ Narcotics Use _____

Immediate Family History

List major family medical problems: ____

Circle which eye conditions run in the family: Cataracts Glaucoma Macular Degeneration Retinal Detachment

List other Family Eye Diseases: ____

Vision Rx History

Circle which apply: Use glasses Use contacts Sleep in contacts Need safety glasses Have glare while driving Use computer often Interested in LASIK

What task do you use your eyes for most of the day? ________________________________

What contact brand and power do you use if you have contacts: ________________________

Review of Systems

Circle any body systems that you have current problems with:

Allergy	Gastrointestinal (Digestion)	Muscle/Skeleton
Cardiovascular (Heart/Blood Vessels)	Reproductive/Urinary	Neurological (Brain/Nerves)
Constitutional	Blood/Lymph	Mental (Psychiatric)
Cranial / Facial	Immune System	Respiratory (Lungs)
Endocrine (Glands)	Integumentary (Skin)	Cancer Hx

Please explain any circled. ____

____

If Diabetes, Type ______ Date of diagnosis _______ Avg. Blood Sugar range ____________ A1C______

Reviewed: _________