Patient History Questionnaire CMS Update 2013

Name: **Date: _____**

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

I attest that there are no changes to my social, medical, or ocular history since the date of my last updated History form. I have the same primary care physician and medications, no new allergies to advise of, and do not have any conditions or other issues to include under the review of systems today.

SIGNED: X_____ Date:_____

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_____