AD ASTRA EYE

PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ Date: _____

Date of Birth: _____ Primary Doctor: _____

Referred By: _____ Pharmacy: _____

Please tell us **what we can help you with** today? _____

Have you ever had or been treated for the any of the following conditions? **If yes please explain**.

Cataracts	Yes No	Eye Trauma	Yes No
Glaucoma	Yes No	Eyes turning in or out	Yes No
Corneal Dystrophy	Yes No	Lazy Eye	Yes No
Macular Degeneration	Yes No	Diabetic retinopathy	Yes No
Iritis	Yes No	Optic nerve disease	Yes No

Other_____

Please list any **EYE surgeries**, with approximate dates:

_____ _____ _____

List any **EYE medications** including over-the-counter medications, i.e. artificial tears:

_____ _____ _____

Immunization history: pneumococcal vaccination Yes No Date:_____

Please state **your medical history** below, **if yes please explain**:

Heart Condition	Yes No _____	Multiple Sclerosis	Yes No
Cancer (**specify types**)	Yes No _____	Hypo/Hyper Thyroid	Yes No
Stroke	Yes No	Stomach Ulcer	Yes No
Diabetes	Yes No	Arthritis	Yes No
High Blood Pressure	Yes No	Lupus	Yes No
Asthma/Emphysema	Yes No	Other_____	
Migraines	Yes No		

Do you have a known **family history** of any of the following? If so, **please state relationship to patient (father, mother, uncle, sister, etc**.)

Glaucoma_____	Heart Disease _____
Cancer_____	Macular Degeneration _____
Cataracts_____	Crossed Eyes_____
Corneal Disease _____	Diabetes_____
High Blood Pressure _____	Other_____

List or **attach a separate sheet** for any **medications** with dosages, including over-the-counter medications, i.e. aspirin:

_____

Please list **any surgeries** you have had:

_____

Do you have any **allergies** to any medications Yes_____No_____
Which medications and reactions? _____
or Latex ? Yes_____No_____
Do you **smoke**? Yes___No____Former. Do you **drink**? Yes_____No___#per week _____
Any other recreational **drugs**? Yes___No____

Review of Systems

Cardiovascular
___chest pain
___irregular heart beat
___shortness of breath
___None

Head, ears, nose, throat
___dizziness
___hearing loss
___hoarseness
___ringing in ears
___sore throat
___None

Musculoskeletal
___back pain
___joint pain
___muscle aches
___stiffness
___swelling
___None

Respiratory
___cough
___trouble breathing
___wheezing
___None

Blood Pressure Control
___good BP control
___borderline BP control
___poor BP control
___unknown BP control
___Not Applicable

Constitutional (overall health)
___fatigue
___fever
___night sweats
___weakness
___weight loss
___None

Hematologic or bleeding problems
___bleeding
___bruising
___tender nodes
___None

Neurological
___balance problems
___headache
___numbness
___tingling
___None

Skin
___hair loss
___rash
___skin lesions
___None

Diabetes Control
___DM control
___borderline DM control
___poor DM control
___unknown DM control
___Not Applicable

Genitourinary
___genital discharge
___genital lesions
___painful urination
___urgency
___None

Metabolic
___cold intolerance
___excess hunger
___excessive thirst
___frequent urination
___heat intolerance
___None

Psychiatric
___anxiety
___depression
___insomnia
___irritability
___nervousness
___None

Allergy
___itching
___hives
___chronic runny nose
___seasonal allergies
___None

Pregnancy
___pregnancy-first trimester
___pregnancy-second trimester
___pregnancy-third trimester
___not pregnant
___Not Applicable