AD ASTRA EYE
M. Scott Hickman, MD

# 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 **(specify)** | Yes No _____ | Multiple Sclerosis | Yes No |
| Cancer (**specify**) | 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 | Yes No |
| 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
____good 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