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 any of the following conditions? **If yes, please explain.**

Cataracts	Yes No	Eye Trauma	Yes No
Glaucoma	Yes No	Eyes turning in (Esotropia)	Yes No
Corneal Dystrophy	Yes No	or out (Exotropia)	Yes No
Macular Degeneration	Yes No	Lazy Eye (Amblyopia)	Yes No
Iritis	Yes No	Diabetic retinopathy	Yes No
Other_____		Optic nerve disease	Yes No

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

_____ _____ _____

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

_____ _____ _____

Covid 19 vaccination history: Vaccination Yes No Approximate month and year _____

Type of vaccine (circle one) Pfizer / Moderna / Johnson & Johnson / _____

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_____	
Migraines	Yes No		

Do you have a known **family history** of any of the following? If so, **please state the 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: _____

AD ASTRA EYE
M. Scott Hickman, MD

Do you have any **allergies** to any medications? Yes__No___
Which medications and reactions? _____

_____

or Latex/Adhesives? Yes____ No____
Do you **smoke**? Yes_____No_____Former _____
Do you **drink**? Yes_____No_____#per week _____
Any other recreational **drugs**? Yes___No_____

Review of Systems – Please Mark Any That Apply:

Eyes
____Previous Surgery
____Contact Lens
____Pain
____Double Vision
____Glaucoma
____Cataract
____Macular Degeneration
____Dry Eye
____Flashes
____Floaters

Ear, Nose and Throat (ENT)
____Hard of Hearing
____Ringing in Ears
____Vertigo
____None

Cardiovascular
____Chest Pain
____Dizziness
____Fainting Spells
____Shortness of Breath
____Irregular Heartbeat
____Difficulty Lying Flat
____None

Constitutional (Overall Health)
____Fatigue/Weakness
____Fever
____Weight Gain/Loss
____None

Respiratory
____Cough
____Congestion
____Wheezing
____Asthma
____None

Gastrointestinal
____Heartburn
____Nausea/Vomiting
____Jaundice/Hepatitis
____None

Genito-Urinary
____Pain/Difficulty
____Blood in Urine
____History of Kidney Stones
____History of STD's
____None

Psychiatric
____Anxiety/Depression
____Mood Swings
____Difficulty Sleeping
____None

Endocrine
____Increased Thirst
____Increased Hunger
____Increased Urination
____Increased Sweating
____Fingernail Changes
____None

Blood/Lymph Nodes
____Easy Bruising
____Gums Bleed Easily
____Prolonged Bleeding
____Heavy Aspirin Use
____None

Musculoskeletal
____Stiffness
____Arthritis
____Joint Pain/Swelling
____None

Skin
____Rash/Sores
____Lesions
____Hives/Eczema
____None

Neurological
____Seizures
____Weakness/Paralysis
____Numbness
____Tremors
____None

Immunologic
____Hives
____Itching
____Runny Nose
____Sinus Pressure
____None

Pregnancy
____ Pregnant _____ Trimester
____Not Pregnant
____Not Applicable