PATIENT HISTORY QUESTIONNAIRE

NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____ **DATE:** _____

PHARMACY: _____ **LOCATION** (street & city) _____

Drug Allergies: **Reaction:**

_____ Rash / shortness of breath / GI upset / other
_____ Rash / shortness of breath / GI upset / other
_____ Rash / shortness of breath / GI upset / other
_____ Rash / shortness of breath / GI upset / other

□ **NO KNOWN DRUG ALLERGIES**

Past Ocular History: (Please mark all that apply) □ **None**

□ Cataracts □ Dry Eye Syndrome □ Retinal Detachment □ Macular Degeneration
□ Glaucoma □ Diabetic Retinopathy □ Keratoconus □ Sudden Vision Loss
Other _____

Ocular Surgeries: (Please mark all that apply **and** the date) □ **None**

□ Cataract Surgery _____ □ LASIK / PRK _____ □ Blepharoplasty _____
□ Retinal laser surgery _____ □ Strabismus surgery (eye muscle) _____
□ Glaucoma Surgery _____ □ Other _____

Past Medical History: (Please mark all that apply) □ **None**

□ High Blood Pressure □ Kidney Disease □ Heart Disease □ Asthma
□ Arthritis □ High Cholesterol □ Anemia □ Lupus
□ Seizures □ Stroke (Date)_____ □ Diabetes (Type I or II) □ Migraines
□ Thyroid Disease □ COPD □ Multiple Sclerosis
□ Cancer (type:_____) □ Other _____

Infections: (Please mark all that apply) □ **None**

□ Herpes Simplex □ Chicken Pox □ HIV / AIDS □ Syphilis
□ MRSA □ Herpes Zoster / Shingles □ Hepatitis A / B / C □ Meningitis
□ Other: _____

Past Surgical History: (Please list all surgeries and the dates) □ **None**

Surgery	Date	Surgery	Date

Medications / Eye Drops / Vitamins: (Please list all current medication) □ **None**

Medication	Dosage	Medication	Dosage

PARAGON EYE ASSOCIATES

NAME: _____ **DATE:** _____

Pregnant: (please circle) **YES / NO** **Breastfeeding:** (please circle) **YES / NO**

Family History: (please indicate on the line whether it pertains to Mother (M), Father (F), Siblings (S) and/ or Grandparents (G)

□ High Blood Pressure _____ □ Diabetes _____ □ Macular Degeneration _____
□ High Cholesterol _____ □ Cancer _____ □ Retinal Detachment _____
□ Stroke (CVA) _____ □ Arthritis _____ □ Blindness _____
□ Heart Disease _____ □ Cataracts _____ □ Glaucoma _____
□ Other: _____

Social History:

Smoking: □ current every day smoker □ social smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes, how much and how often? _____

Drug Use: □ Yes □ No If yes, what and how often? _____

Review of Systems: (Please mark all that apply) □ **None** □ **Other:** _____

Eyes
□ Contact Lenses
□ Pain
□ Double Vision
□ Dry Eyes
□ Flashes
□ Floaters

Ears, Nose and Throat
□ Vertigo
□ Ringing in ears
□ Hard of hearing

Cardiovascular
□ Chest Pain
□ Shortness of Breath
□ Dizziness
□ Fainting Spells
□ Irregular Heartbeat
□ Difficulty Lying Flat

Constitutional
□ Fever / Chills
□ Weight Gain / Loss
□ Fatigue/ Weakness

Respiratory
□ Cough
□ Congestion
□ Wheezing
□ Asthma

Gastrointestinal
□ Heartburn
□ Nausea / Vomiting
□ Jaundice / Hepatitis

Genitourinary
□ Pain / Difficulty
□ Blood in Urine
□ History of Kidney Stones
□ History of STD's

Psychiatric
□ Anxiety / Depression
□ Difficulty Sleeping
□ Mood Swings

Endocrine
□ Increased Sweating
□ Increased Urination
□ Increased Hunger
□ Increased Thirst
□ Fingernail Changes

Blood / Lymph Nodes
□ Easy Bruising
□ Gums Bleed Easily
□ Prolonged Bleeding
□ Heavy Aspirin Use

Musculoskeletal
□ Stiffness
□ Arthritis
□ Joint Pain / Swelling

Skin
□ Rash / Sores
□ Lesions
□ Eczema / Itching

Neurological
□ Seizures
□ Weakness / Paralysis
□ Numbness / Tingling
□ Tremors

Immunologic
□ Hives
□ Itching
□ Runny Nose
□ Sinus Pressure

Signature: Date: