

Nicolitz Eye Consultants

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- Oculoplastics
- Cosmetic Surgery
- Contact Lenses

- Laser Surgery
- General Ophthalmology
- Prelex

- Refractive Surgery
- LASIK / LASEK
- Restylane / Radiance

Health Questionnaire

Social History

Date _____

Name: _____ DOB: _____

Do you smoke? Yes No How many packs a day? _____ How many years? _____
Do you drink alcohol? Yes No How much? Rarely Occasionally Daily In excess
Do you use street drugs? Yes No What kinds? _____

Past Medical History

Please list medications you are allergic to: _____

Please list all major illnesses, hospitalizations, and surgeries with their approximate dates:

- | | | |
|----------|----------|-----------|
| 1) _____ | 5) _____ | 9) _____ |
| 2) _____ | 6) _____ | 10) _____ |
| 3) _____ | 7) _____ | 11) _____ |
| 4) _____ | 8) _____ | 12) _____ |

Please list all of the medications that you take regularly, their doses and how often taken:

- | | | |
|----------|----------|-----------|
| 1) _____ | 5) _____ | 9) _____ |
| 2) _____ | 6) _____ | 10) _____ |
| 3) _____ | 7) _____ | 11) _____ |
| 4) _____ | 8) _____ | 12) _____ |

Family History (Check or answer all that apply)

Relation	Living	Age	Dead	Cause	Cataracts	Glaucoma	Macular Degeneration	Detached Retina	Diabetes
Father									
Mother									
Brothers									
Sisters									
Children									

Review of Eye Health

Loss of vision Yes No Please explain _____

- | | | | |
|-------------------|------------------------------|-----------------------------|----------------------|
| Blurred vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |
| Double vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |
| Dryness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |
| Excess tearing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |
| Redness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |
| Gritty Feeling | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |
| Itching | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |
| Burning | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |
| Eye pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |
| Light sensitivity | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |
| Discharge | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |

Have any of these eye problems caused you to decrease or discontinue any of the following:

- | | | | |
|--------------------------|------------------------------|-----------------------------|----------------------|
| Driving during the day | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |
| Driving during the night | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |
| Reading | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |
| Hobbies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |
| Sports | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |
| Employment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |
| Other _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Please explain _____ |

Review of Overall Health

Please sign: _____ **Reviewed by:** _____

General

- Chills
- Depression/Nervousness
- Dizziness/Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight

Cardiovascular

- Chest pain
- High/Low blood pressure
- Irregular/rapid heart beat
- Poor circulation
- Swelling of ankles

Gastrointestinal

- Appetite poor
- Excessive thirst
- Rectal bleeding
- Vomiting

Skin

- Bruise easily
- Hives
- Itching/rash
- Changes in moles
- Scars
- Sore that won't heal
- Skin cancer

Ear, Nose and Throat

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache/Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Flashes in eyes
- Halos around light

Muscle/Joint/Bone

- Pain, weakness or numbness in:*
- | | |
|--------------------------------|------------------------------------|
| <input type="checkbox"/> Arms | <input type="checkbox"/> Hips |
| <input type="checkbox"/> Back | <input type="checkbox"/> Legs |
| <input type="checkbox"/> Feet | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Hands | <input type="checkbox"/> Shoulders |

Genito-Urinary

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

Other

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Prostate problem |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pregnant |

