Nicolitz Eye Consultants

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Health Questionnaire   Date__________________

Name:_ **DOB:**_ _ _ _ _

Past Medical/Family/Social History

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? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Do you drive? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No *(In case any surgical procedures are necessary)*

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

1) ______________________________________ Date: _ _ _ _ _ _ _ _ _ _

2) ______________________________________ Date: _ _ _ _ _ _ _ _ _ _

3) ______________________________________ Date: _ _ _ _ _ _ _ _ _ _

4) ______________________________________ Date: _ _ _ _ _ _ _ _ _ _

Family History (Check or answer all that apply)

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

Please list medications you are allergic to:____

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

1)____________________ Dose:______________ mg How often:_______________________
2)____________________ Dose:______________ mg How often:_______________________
3)____________________ Dose:______________ mg How often:_______________________
4)____________________ Dose:______________ mg How often:_______________________
5)____________________ Dose:______________ mg How often:_______________________

Review of Eye Health (please circle)

Cataracts	**Yes**	**No**	Glaucoma	**Yes**	**No**
Retina or macula condition	**Yes**	**No**	Dryness	**Yes**	**No**
Excess tearing or discharge	**Yes**	**No**	Redness	**Yes**	**No**
Halos around lights	**Yes**	**No**	Gritty Feeling	**Yes**	**No**
Light sensitivity	**Yes**	**No**	Burning	**Yes**	**No**
Loss of vision	**Yes**	**No**	Itching	**Yes**	**No**
Blurred vision	**Yes**	**No**	Eye pain	**Yes**	**No**

Double vision **Yes** **No** Please explain _

Flashes or floaters **Yes** **No** Please explain _

Crossed eyes **Yes** **No** Please explain ____

Other: -

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

Driving during the day **Yes** **No** Please explain ____________________________________

Driving during the night **Yes** **No** Please explain ____________________________________

Reading **Yes** **No** Please explain ____________________________________

Hobbies or sports **Yes** **No** Please explain ____________________________________

Employment **Yes** **No** Please explain ____________________________________

Other **Yes** **No** Please explain ____________________________________

Review of Overall Health

Constitutional
- ☐ Fever
- ☐ Fatigue
- ☐ Night Sweats
- D Chills
- ☐ Malaise
- ☐ Appetite Changes
- ☐ Weight Changes

Cardiovascular
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Heart Attack
- ☐ Varicose Veins
- D High Cholesterol
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Murmur
- ☐ Mitral Valve Prolapse

Gastrointestinal
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Indigestion
- ☐ Trouble Swallowing
- ☐ Stool Changes
- ☐ Hemorrhoids

Endocrine
- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Cold/Heat Intolerance
- ☐ Goiter
- ☐ Hair Loss
- ☐ Hypoglycemia
- D Thyroid

Ear/Nose/Throat
- ☐Fever
- ☐Fatigue
- ☐Night Sweats
- ☐ Chills
- ☐ Malaise
- ☐Appetite Changes
- ☐Weight Changes

Respiratory
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Heart Attack
- ☐ Varicose Veins
- D High Cholesterol
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Murmur
- ☐ Mitral Valve Prolapse

Genitourinary
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Indigestion
- ☐ Trouble Swallowing
- ☐ Stool Changes
- ☐ Hemorrhoids

Neurological
- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Cold/Heat Intolerance
- ☐ Goiter
- ☐ Hair Loss
- ☐ Hypoglycemia
- D Thyroid

Skin
- ☐ Unusual Rashes
- ☐ Itching
- ☐ Lumps
- ☐ Dryness
- ☐ Melanoma

Psychiatric
- ☐ Panic Attacks
- ☐ Anxiety
- ☐ Depression
- ☐ Manic-depression
- ☐ Mania
- ☐ Past Suicide Attempts

Musculoskeletal
- ☐ Joint pain/swell
- ☐ Weakness
- ☐ Abnormal Gait
- ☐ Back Pain
- ☐ Stiffness
- ☐ Muscle Aches
- ☐ Leg Cramps
- ☐ Arthritis

Hematologic
- ☐ Easy Bruisability
- ☐ Excessive Bleeding
- ☐ Enlarged Lymph Nodes
- ☐ Anemia

OTHER:
- ☐ Aids
- ☐ Hepatitis
- ☐ Herpes Virus

Please sign: ________________________ **Reviewed by:**