TEXAS RETINA ASSOCIATES

Patient History Questionnaire Page 1

Name: **Date:**

Allergies and Drug Reactions:

Medications:

Review of Systems: If you are currently having any problems in the following areas please circle below.

Allergy/Immunology: environmental allergies, food allergies, other:

Cardiovascular: chest pressure, discomfort, irregular heartbeat, other:

Constitutional: fatigue, fever, night sweats, other:

Endocrine: cold intolerance, heat intolerance, other:

Ear, Nose, Throat: hearing loss, sinus problems, hoarseness, other:

Gastrointestinal: constipation, diarrhea, vomiting, other:

Genitourinary: frequent urination, incontinence, back pain, other:

Blood/Lymph Nodes: bruising, easy bleeding, swelling, other:

Skin (Integumentary): rash, skin lesion, infection, other:

Musculoskeletal: joint swelling, muscle weakness, stiffness, other:

Neurological: dizziness, tremors, headache, other:

Psychiatric: mood swings, anxiety, depression, other:

Respiratory: cough, wheezing, snoring, other:

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Patient History Questionnaire Page 2

Name: **Date:**

Ocular Medical History: Please list all eye diseases or surgeries.

Medical History: Please check the following if they apply to yourself (S).

S		S		S	
	Anemia		Emphysema/COPD		Meningitis
	Arthritis		Heart Attack		Seizures
	Asthma		Hepatitis		Sexually Transmitted Disease
	AIDS		High Blood Pressure		Stroke
	Cancer		Kidney Disease		Thyroid Disease
	Diabetes		Lyme Disease		Vascular Disease

Previous Injuries, Surgeries, Treatments, Hospitalizations and Other Medical Problems:

Family History: Please specify family relationship if they apply under (F), ex: mother, father, etc.

F		F		F	
	Anemia		Emphysema/COPD		Retinal Disease
	Arthritis		Glaucoma		Retinal Detachment
	Asthma		Heart Attack		Seizures
	Blindness		High Blood Pressure		Stroke
	Cancer		Kidney Disease		Thyroid Disease
	Diabetes		Macular Degeneration		Vascular Disease

Social History:

Do you use any tobacco products? (if yes, what type & for how long)

Have you ever used tobacco products before? (if yes, what type & for how long)

Do you drink alcohol? (if yes, explain) _____

Do you use street drugs? (if yes, explain) _____