HEALTH HISTORY QUESTIONNAIRE

Name: _____ **DOB:** _____ **Sex:** ☐ M ☐ F **Age:** _____

Name of Current Primary Care Provider: _____ **Cardiologist:(If applicable)** _____

Vaccine: ☐Pneumonia ☐Influenza ☐Covid-19

Ocular History:

YES	NO	
☐	☐	**Contact Lens Wearer**
		☐ Soft – Daily or Monthly Replacement
		☐ Rigid, Scleral, Other
☐	☐	**Cataract Surgery: R L Both**
☐	☐	**LASIK or other refractive Surgery: Year ____**
☐	☐	Significant Eye Trauma: Year _____
☐	☐	Macular Degeneration
☐	☐	Glaucoma
☐	☐	Diabetic Retinopathy
☐	☐	Family History of Blindness

Ears:

☐	☐	Hearing Loss: R L Both
☐	☐	Hearing Aids: R L Both

Dermatological:

☐	☐	Rosacea
☐	☐	Eczema
☐	☐	Derm. Disease: Other _____

Endocrine:

☐	☐	Thyroid Disease: Hyper or Hypo
☐	☐	Diabetes – Insulin, pills, or diet controlled

Cardiovascular:

☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Heart Attack: Year _____
☐	☐	Atrial Fibrillation/Palpitations
☐	☐	Chest pain/Angina
☐	☐	History of Congestive Heart Failure
☐	☐	Pacemaker or Implanted defibrillator
☐	☐	Heart Disease: Other _____

Respiratory:

☐	☐	Shortness of breath
☐	☐	Asthma
☐	☐	COPD
☐	☐	Sleep Apnea
☐	☐	CPAP/BIPAP
☐	☐	Respiratory Disease: Other _____

Autoimmune:

☐	☐	Lupus / Sjogrens / Rheumatoid Arthritis
☐	☐	Autoimmune: Other _____

Gastrointestinal:

☐	☐	Gastrointestinal Disease: _____

Musculoskeletal:

☐	☐	Arthritis: Osteoarthritis
☐	☐	Difficulty walking / Increase Fall Risk

Genitourinary:

YES	NO	
☐	☐	Kidney Disease
☐	☐	Dialysis: Hemo/peritoneal (M T W TH F)
☐	☐	***Ever* taken Flomax or Rapaflo, Tamsulosin?**

Hematologic:

☐	☐	HIV+
☐	☐	Anemia
☐	☐	Sickle Cell Anemia
☐	☐	Blood thinning medication other than aspirin
☐	☐	History of blood clots
☐	☐	Heme Diseases: Other _____

Neurological:

☐	☐	Stroke: Year _____
☐	☐	Parkinson's disease
☐	☐	Epilepsy: last seizures _____
☐	☐	Alzheimer's or Senile Dementia
☐	☐	Restless Leg Syndrome
☐	☐	Neurologic Disease: Other _____

Other:

☐	☐	Are you currently **pregnant**?
☐	☐	Depression / Anxiety
☐	☐	Substance Abuse / Addiction
☐	☐	Cancer- what type _____
		Current treatment _____

THIS SHOULD BE COMPLETED BY APPLICABLE PATIENTS

Necessary Augusta Eye MD to receive full insurance compensation

All Patients:

☐ Y ☐ N Do you **currently** use any tobacco products?

If referred to Augusta Eye MD by your primary care doctor, a specialist or another eye care provider, please provide the name and clinic: _____

Patients Over 65:

☐ Y ☐ N Have you received a **pneumonia** vaccination?

☐ Y ☐ N If you are unable to make a medical decision, have you decided on someone to make decisions on your behalf?

Diabetic Patients:

What is the name and clinic of the provider currently managing your diabetic care, prescribing your medications?

_____

Please Turn Over

Surgical History

Please List All Previous Surgeries (**Including Eye Surgeries)** and Approximate Dates

_____

_____

_____

_____

_____

Medical Allergies:

YES	NO	
□	□	Penicillin
□	□	Sulfa
□	□	Latex and/or rubber
□	□	Betadine/Iodine

OTHER ALLERGIES / **RESPONSE** / **SEVERITY**

_____/_____/_____

_____/_____/_____

_____/_____/_____

_____ /_____/_____

Please List All Prescriptions Medications, Over the Counter, Vitamins, And Dietary Supplements:

Medication	Dose	How Often		Medication	Dose	How Often