PROFFITT EYE CENTER MEDICAL HISTORY QUESTIONNAIRE/REVIEW OF SYSTEMS

Name _____ Birth Date _____

Do you ***currently*** have any problems in, or are being treated for, the following areas?
If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
FEMALES Are you pregnant? Nursing?			
EARS, NOSE THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, sinus problems, etc.)			
CARDIOVASCULAR (high blood pressure, racing pulse, heart disease, pacemaker, defibrillator, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, asthma, emphysema, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, prostate, yellow jaundice, dialysis, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, Rheumatoid arthritis, etc.)			
SKIN (pimples, warts, growths, rash, skin cancer)			
NEUROLOGICAL (numbness or tingling, headache, seizures, paralysis, multiple, sclerosis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, dementia)			
ENDOCRINE (diabetes, hypothyroid, excessive thirst, etc.)			
BLOOD/LYMPH (bleeding, high cholesterol, anemia, problems related to blood transfusion, bruise easily, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, hepatitis, HIV/AIDS, etc.)			
CANCER (list type)			

FAMILY HISTORY (Mother, Father, Grandparents, Siblings)

Has any member of your family had these diseases (circle all that apply)? **YES NO UNKNOWN**
Blindness Cataract Glaucoma Diabetes Macular Degeneration
Other heritable disease:

SOCIAL HISTORY

Do you drink alcohol? **YES NO** Do you use Tobacco? **YES NO**

Have you ever had tuberculosis? **YES NO** Have you ever had a blood transfusion? **YES NO**

List **all major injuries** sustained in the past year (concussion, etc.): **None /** _____
List **all eye injuries** sustained during your lifetime: **None /** _____
List **any eye surgeries** you have had: **None /** _____

DATE COMPLETED:_____

Patient's Signature **X**_____ Physician's Signature _____
(Form Updated 1/24/14)