SFRI Patient History Questionnaire

Name _____ Date of Birth _____

Address_____Phone Number: _____

Primary Physician: _____ City: _____

Previous Ophthalmologist: _____ City: _____

Referring Physician:_____ City: _____

Current Medications: _____

_____

Allergies to Medication
List all allergies to medications: _____

Review of Systems:
Please check **YES** or **NO** in bold boxes. If yes, specify in small boxes and explain.

HIV/AIDS……YES NO

History of COVID19 Positive…….YES NO

Eye……	**YES**	**NO**	(If no, proceed to next topic) Explanation of problem
Blurry Vision……	❑	❑	_____
Distorted vision……	❑	❑	_____
Double vision……	❑	❑	_____
Dryness…….	❑	❑	_____
Excess tearing/watering……	❑	❑	_____
Foreign body sensation……	❑	❑	_____
Glare/light sensitivity……..	❑	❑	_____
Itching……..	❑	❑	_____
Loss of side vision……	❑	❑	_____
Mucous discharge…….	❑	❑	_____
Pain or soreness……	❑	❑	_____
Redness……	❑	❑	_____
Stye, Chalazion……..	❑	❑	_____
Other…….	❑	❑	_____

Eye History	**YES**	**NO**	**When Diagnosed**	**Treatment**
Cataract	❑	❑	_____	_____
Glaucoma	❑	❑	_____	_____
Eye muscle problems	❑	❑	_____	_____
Retina Problems	❑	❑	_____	_____
Corneal Problems	❑	❑	_____	_____
Injury	❑	❑	_____	_____
Other	❑	❑	_____	_____

Current Eye Medications: _____
_____

Past Eye Surgery **Date**
Operation(s)/Laser Treatment(s) _____ _____
_____ _____

Ear, Nose, Mouth, Throat……YES NO (If no, proceed to next topic)
Explanation of problem

Sinus congestion/Post-nasal drip…….	❑	❑	_____
Difficulty swallowing……..	❑	❑	_____
Pain chewing……	❑	❑	_____
Chronic cough…….	❑	❑	_____
Dry throat/mouth…….	❑	❑	_____
Other……	❑	❑	_____

Cardiovascular…… YES NO (If no, proceed to next topic)
Explanation of problem

Congestive heart failure……	❑	❑	_____
Heart murmur/Mitral valve prolapse……	❑	❑	_____
Heart attacks…….	❑	❑	_____
Other……..	❑	❑	_____
Open heart surgery/Angioplasty (describe)			_____

Respiratory (Lungs/Breathing)**……. YES NO** **(**If no, proceed to next topic)
Explanation of problem

Shortness of breath…….	❑	❑	_____
Tuberculosis……..	❑	❑	_____
Lung cancer……	❑	❑	_____
Sarcoidosis……	❑	❑	_____
Other……..	❑	❑	_____
Surgery			_____

Gastrointestinal (Stomach/Intestines)**…….. YES NO** (If no, proceed to next topic)
Explanation of problem

Jaundice/Hepatitis……..	❑	❑	_____
Cancer…….	❑	❑	_____
Other……..	❑	❑	_____
Surgery			_____

Genitourinary (Genitals/Kidney/Bladder)**…. YES NO** (If no, proceed to next topic)
Explanation of problem

Kidney disease……	❑	❑	_____
Prostate cancer…….	❑	❑	_____
Cervical/Uterine/Ovarian/Breast Cancer…….	❑	❑	_____
Pregnant now?…….	❑	❑	_____
Surgery			_____

Integumentary (Skin and/or breast)**…… YES NO** (If no, proceed to next topic)
Explanation of problem

Skin disease/cancer……...	❑	❑	_____
Shingles……..…	❑	❑	_____
Other…….	❑	❑	_____
Surgery			_____

Musculo-Skeletal……..… **YES NO** (If no, proceed to next topic)
Explanation of problem

Arthritis……	❑	❑	_____
Cancer……..	❑	❑	_____
Other……	❑	❑	_____
Surgery			_____

Neurological……	**YES**	**NO**	(If no, proceed to next topic) Explanation of problem
Stroke/Paralysis……..	❑	❑	_____
Cancer……..	❑	❑	_____
Alzheimer's…….	❑	❑	_____
Other……	❑	❑	_____
Surgery			_____

Psychiatric…….	**YES**	**NO**	(If no, proceed to next topic) Explanation of problem
Other……..	❑	❑	_____

Hematologic/Lymphatic……	**YES**	**NO**	(If no, proceed to next topic) Explanation of problem
Anemia…….	❑	❑	_____
Sickle cell disease……	❑	❑	_____
Leukemia/Blood cancer…….	❑	❑	_____
Lymphoma…….	❑	❑	_____
Surgery			_____

Allergic/Infectious……	**YES**	**NO**	(If no, proceed to next topic) Explanation of problem
Immune problems…….	❑	❑	_____
HIV/AIDS…….	❑	❑	_____
Other…….	❑	❑	_____
Surgery			_____

Endocrine…….	**YES**	**NO**	(If no, proceed to next topic) Explanation of problem
Diabetes…….	❑	❑	_____
Cancer-pancreas/adrenal glands……	❑	❑	_____
Thyroid problems…….	❑	❑	_____
Other…….	❑	❑	_____
Surgery			_____

Other……

_____ _____

_____ _____

Past Social History

Past History

Describe any other problems, illnesses, surgeries, or medicines that were not described in the above questions.

_____

_____

Social History	**YES**	**NO**	**Explanation**
Toxic exposures	❑	❑	_____
Recent voyages	❑	❑	_____
Other	❑	❑	_____

Date _____ Patient Signature_____

Date _____ Physicians Signature_____