Retina Specialists of Southern Arizona, P.L.L.C
Patient History Questionnaire

Name: _____ Date of Birth:_____ Date: _____

Please state reason for visit: _____

Previous eye conditions and surgeries: _____ ____None

List ALL Medical Conditions:

□ Diabetes Type I ___years □ Diabetes Type II ___ years □ High Blood Pressure □ Heart Disease
□ Kidney Dialysis/Disease □ Bleeding Disorder □ Thyroid Disease □ HIV/AIDS
□ High Cholesterol □ Vascular Disease □ Lung Disease □ Cancer □ Stroke

List Other Medical Problems and Major Surgeries: ____None

_____

List ALL Current Medications (include non-prescription drugs): ____No medications

_____

Allergies and Drug Reactions: ____No known drug allergies

_____

Social History: Check answer
Do you drink alcohol? □ No □ Yes (if yes, how often?) _____
Do you currently smoke, chew/use cigars? □ No □ Yes (if yes, how often?) _____
If you no longer smoke, when did you quit? _____
Do you abuse drugs? □ No □ Yes (if yes, explain) _____
Do you drive? □ No □ Yes
Do you live alone? □ No □ Yes
Do you reside in a skilled nursing facility / assisted living? □ No □ Yes
Have you ever had a blood transfusion? □ No □ Yes

Family History: Do you have any relatives with: ___ Glaucoma? _____

___ Macular Degeneration? _____

___ Other? _____

Patient History Questionnaire (cont.)

Name: _____ Date of Birth:_____ Date: _____

Review of Systems:

If you are currently having any problems in the following areas, please circle and explain.

CONSTITUTIONAL: fever, weight loss, fatigue, trouble standing from chair: ☐ none

SKIN: itching, rash, infection, ulcer, tumors (growths), other: ☐ none

LYMPHATIC: swelling or tenderness of lymph nodes, other: ☐ non:

MUSCULOSKELETAL: muscle pain, cramps, joint pain, swelling, other: ☐ none

ENDOCRINE: confusion, fainting, nervousness, hot/cold intolerance, hair loss: ☐ none

ALLERGY/IMMUNOLOGY: recurrent infections, hay fever, hives, food/drug allergy: ☐ none

HEAD: headaches, dizziness, vertigo, other: ☐ none

EARS: hearing loss, ringing, infections, other: ☐ none
NOSE: bleeding, loss of smell, congestion, sinus problems, other: ☐ none
THROAT: dry mouth, loss of taste, difficulty swallowing, hoarseness, other: ☐ none

NECK: pain, swelling, stiffness, other: ☐ none

BREAST: tenderness, swelling, lumps, discharge, other: ☐ none

HEMATOLOGIC: fever/chills; bruise easily, prolonged bleeding, skin hemorrhages ☐ none

RESPIRATORY: wheezing, cough, difficulty breathing, asthma, other: ☐ none

CARDIOVASCULAR: (heart/ blood vessels): chest pain, swelling of extremities, shortness of breath, exercise intolerance, other: ☐ none

GASTROINTESTINAL: (stomach/intestines): nausea, vomiting, constipation, diarrhea, pain/cramps, bleeding, other: ☐ none

GENITOURINARY: (genitals/kidney/bladder): frequency, burning, pain or bleeding on urination, infections, incontinence, other: ☐ none

NEUROLOGIC: weakness in arms or leg, numbness, or tingling, loss of consciousness, falls, difficulty walking, seizures, tremors, neuralgia, other: ☐ none

PSYCHIATRIC: disorientation, mood swings, anxiety, depression, hallucinations ☐ none

Was this form completed by: ☐ Patient ☐ Family ☐ Staff