

EYE SPECIALISTS OF WESTCHESTER
PATIENT HISTORY QUESTIONNAIRE

Mr.

Mrs.

NAME Miss _____

HOME TEL. _____ BUS. TEL. _____

ADDRESS _____

City _____ State _____ Zip _____ SS # _____

INSURANCE _____

EMPLOYER _____

TODAY'S DATE _____

DATE OF BIRTH _____

AGE _____

NAME OF PERSON WHO REFERRED YOU _____

PRIMARY CARE PHYSICIAN _____

PAST HISTORY

List any medications you currently take _____

List all major illnesses and injuries _____

List any surgeries you have had _____

Do you have allergies to any medications? YES NO

If YES, list medications _____

FAMILY HISTORY

Disease: YES NO Relationship to Patient

Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attacks	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sjogrens Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

Current Occupation _____

Do you drink alcohol? YES NO

If YES, how often? _____

Do you smoke? YES NO

If YES, how many packs a day? _____

PLEASE COMPLETE OTHER SIDE

REVIEW OF SYSTEMS

Do you currently have problems in the following areas? If "YES," provide information.

	YES	NO	Explanation of Problem
Constitutional Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	
Distorted vision (halos)	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	
Redness	<input type="checkbox"/>	<input type="checkbox"/>	
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	
Itching	<input type="checkbox"/>	<input type="checkbox"/>	
Burning	<input type="checkbox"/>	<input type="checkbox"/>	
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	
Occasional tearing	<input type="checkbox"/>	<input type="checkbox"/>	
Glare/Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	
Sties, Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	
Ears, Nose, mouth, throat	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	
Post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	
Dry throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	
Heart/Blood vessels	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory (lungs/breathing)	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach/Intestines	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Muscle	<input type="checkbox"/>	<input type="checkbox"/>	
Joint	<input type="checkbox"/>	<input type="checkbox"/>	
Integumentary (skin and/or breast)	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	
Hematologic/Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	
Blood	<input type="checkbox"/>	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	
Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	
Head allergy symptoms	<input type="checkbox"/>	<input type="checkbox"/>	
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Hay fever symptoms	<input type="checkbox"/>	<input type="checkbox"/>	

History Reviewed by Physician:

Franklin L. Bocian, M.D.

Bradley H. Scharf, M.D.