ROBERT CIZIK EYE CLINIC

PATIENT HEALTH QUESTIONNAIRE

NAME_____DATE OF BIRTH_____AGE_____

Who sent you to see us today? _____

What do you want us to help you with? _____

PLEASE LIST THE NAMES OF YOUR HEALTH CARE PROVIDERS

Please put a * by the names of those who would like a copy of our report

NAME ADDRESS/PHONE

FAMILY/PRIMARY CARE _____

NEUROLOGIST _____

OPHTHALMOLOGIST _____

PHARMACY _____

OTHER _____

MEDICAL HISTORY: Mark below any illness you have or have had

No___ Yes___ ANEMIA
No___ Yes___ ASTHMA
No___ Yes___ ARTHRITIS
No___ Yes___ BLOOD CLOTS
No___ Yes___ CANCER
No___ Yes___ DIABETES
No___ Yes___ HEART DISEASE
No___ Yes___ LUNG DISEASE
No___ Yes___ HEPATITIS TYPE____
No___ Yes___ HIGH BLOOD PRESSURE
No___ Yes___ HIGH CHOLESTEROL
No___ Yes___ MULTIPLE SCLEROSIS
No___ Yes___ RHEUMATIC FEVER
No___ Yes___ SEIZURES
No___ Yes___ STROKE
No___ Yes___ THYROID PROBLEMS
No___ Yes___ SLEEP APNEA
No___ Yes___ POLYCYSTIC OVARIAN SYNDROME
No___ Yes___ PSYCHIATRIC PROBLEMS (DEPRESSION/ANXIETY/BIPOLAR)

OTHER_____

EYE HISTORY: Mark below any eye problems or surgeries you have or have had

No___ Yes___ CATARACTS
No___ Yes___ CATARACT SURGERY
No___ Yes___ GLAUCOMA/SURGERY
No___ Yes___ MACULAR DEGENERATION
No___ Yes___ EYELID SURGERY
No___ Yes___ RETINAL DISEASE/SURGERY
No___ Yes___ CORNEAL DISEASE/SURGERY
No___ Yes___ AMBLYOPIA
No___ Yes___ TRAUMA
No___ Yes___ OPTIC NEURITIS
No___ Yes___ UVEITIS
No___ Yes___ THYROID EYE DISEASE
No___ Yes___ ORBITAL FRACTURE/SURGERY
No___ Yes___ STRABISMUS/SURGERY

OTHER_____

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PLEASE LIST THE TYPE AND DATES OF ANY SURGERIES YOU HAVE HAD:

_____

_____

_____

LIST **ANY** MEDICATIONS THAT YOU ARE CURRENTLY TAKING WITH DOSE AND FREQUENCY
(including vitamins, aspirin, eye drops, herbals, or homeopathic remedies)

_____

_____

_____

_____

_____

LIST ALLERGIES TO MEDICATIONS _____

_____

WHAT EVALUATIONS YOU HAVE HAD IN THE PAST?

TEST	APPROXIMATE DATE	LOCATION
CT		
MRI		
X-RAYS		
BLOOD WORK		
EEG, EKG, OTHER		

SOCIAL HISTORY

MARITAL STATUS _____

OCCUPATION _____

ALCOHOL USE	CURRENT	YES / NO	How Much?_____
	PAST	YES / NO	How Much?_____
TOBACCO USE	CURRENT	YES / NO	How Much?_____
	PAST	YES / NO	How Much?_____
STREET DRUGS	CURRENT	YES / NO	How Much?_____
	PAST	YES / NO	How Much?_____

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FAMILY HISTORY: PLEASE LIST ANY FAMILY MEMBERS INCLUDING GRANDPARENTS, PARENTS, SIBLINGS, AUNTS, UNCLES, AND CHILDREN WHO MAY HAVE THE FOLLOWING:

		PROBLEM	FAMILY MEMBER
No___	Yes___	ANEMIA	_____
No___	Yes___	ARTHRITIS	_____
No___	Yes___	CANCER	_____
No___	Yes___	DIABETES	_____
No___	Yes___	DEPRESSION	_____
No___	Yes___	EYE PROBLEMS	_____
No___	Yes___	HEADACHES	_____
No___	Yes___	HEART DISEASE	_____
No___	Yes___	HIGH BLOOD PRESSURE	_____
No___	Yes___	MULTIPLE SCLEROSIS	_____
No___	Yes___	OBESITY	_____
No___	Yes___	SEIZURES	_____
No___	Yes___	STROKE	_____
No___	Yes___	THYROID PROBLEMS	_____
No___	Yes___	TUBERCULOSIS	_____
No___	Yes___	BLOOD CLOTS	_____
No____	Yes___	OTHER	_____

REVIEW OF SYMPTOMS:

CURRENTLY OR IN THE PAST 6 MONTHS HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? PLEASE <u>CHECK</u> YES OR NO NEXT TO SYMPTOM.

CONSTITUTIONAL:

No___ Yes___ General poor health, fevers, chills, night sweats
No___ Yes___ Loss of appetite
No___ Yes___ Feel at risk for HIV or AIDS

SKIN:

No___ Yes___ Skin rash, sores, change of a mole, lumps

HEAD/EARS/NOSE/THROAT:

No___ Yes___ Diminished hearing, tinnitus, hoarseness or sinus problems
No___ Yes___ Dizziness, passing out, motion sickness
No___ Yes___ Swallowing problems, choking, sore throat, mouth, tongue
No___ Yes___ Unusual/new pain in temples, jaw pain when chewing, scalp pain

CARDIOVASCULAR:

No___ Yes___ Chest pain or pressure, rapid or irregular heartbeats
No___ Yes___ "Blacking out" or loss of consciousness
No___ Yes___ Known difficulty with a heart valve, heart murmur
No___ Yes___ Awakening at night with shortness of breath
No___ Yes___ Swelling of legs or feet
No___ Yes___ Pain in the calves when you walk

GASTROINTESTINAL:

No___ Yes___ Heartburn, reflux, bloating
No___ Yes___ Frequent nausea, vomiting or stomach trouble
No___ Yes___ Constipation or diarrhea more than twice a month
No___ Yes___ Changes in bowel movement / blood in stools / other

GENITOURINARY:

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No___ Yes___ Problems with urinary stream, completely emptying your bladder
No___ Yes___ Frequency, urgency, urinating at night, leaking or burning, blood in urine, discharge
No___ Yes___ Concern regarding sexually transmitted disease

ENDOCRINE:

No___ Yes___ Heat intolerance
No___ Yes___ Fatigued most of the time
No___ Yes___ Weight loss or gain of more than 10 pounds during the last six months
No___ Yes___ Excess hunger, excess thirst

RESPIRATORY/SLEEP:

No___ Yes___ Can't walk far or climb stairs without shortness of breath
No___ Yes___ Emphysema, chronic bronchitis, coughing spells, coughing blood
No___ Yes___ Experiencing any allergy symptoms
No___ Yes___ Problems falling asleep, staying asleep
No___ Yes___ Disruptive snoring, wake yourself snoring/choking

MUSCULOSKELETAL:

No___ Yes___ Unusual pain, stiffness or swelling in your back, joints or muscles

PSYCHIATRIC:

No___ Yes___ Experiencing an *unusually* stressful situation
No___ Yes___ Experiencing *excessive* anxiety or hallucinations or delusions
No___ Yes___ Suicidal thoughts, suicidal plans

HEME/LYMPH:

No___ Yes___ Excessive bruising, bleeding
No___ Yes___ Enlarged glands (lymph nodes) in groins or armpits

HEIGHT: _____

MAXIMUM WEIGHT: _____ YEAR: _____ CURRENT WEIGHT: _____

MEN ONLY:

No __ Yes __ Have you used or do you use medication for erectile dysfunction?

WOMEN ONLY:

Approximate date of your last mammogram: _____

Birth Control: _____

Complications from Birth Control: _____

Pregnancies:

How many children were born alive? How many children were born stillborn? How many premature births?
How many Cesarean Sections?
Any miscarriages?

PATIENT SIGNATURE:

_____