Davis Hawley Eyecare
Medical History Update

(If it has been more than 3 years since you completed a Patient History Questionnaire, please complete a new Patient History Questionnaire instead of this update. Thank you for your assistance!)

Today's Date: _____ **Patient's Date of Birth**: _____

First Name: _____ **Middle Initial**: _____**Last Name**: _____

E-mail address: _____

Current family physician or internist name, address and phone number: _____
_____

If you are here today with an eye, vision, or medical problem, please describe your main reason(s) for coming in to see us today:
_____
_____

[For the questions below, if the answer is yes, please give details in the space provided!]

HAVE YOU EVER been diagnosed with diabetes, pre-diabetes, or hypertension (high blood pressure)? PLEASE DETAIL. □ No □Yes
_____

Have any **family members** (blood relatives) **EVER** been diagnosed with glaucoma or other eye disease? □ No □Yes
_____

Since your last visit here, has your vision become blurred? □ No □Yes
_____

Since your last visit here, have you begun to see any flashes of light or spots? □ No □Yes
_____

Since your last visit here, have you had any EYE surgery or EYE or HEAD injuries? □ No □Yes
_____

Since your last visit here, have you been treated elsewhere for any EYE conditions, such as red eye? □ No □Yes
_____

Since your last visit here, have you begun to take any new medications (including eyedrops, supplements or vitamins)? □ No □Yes
_____

Since your last visit here, Have you stopped taking any medications that you had previously listed on the Questionnaire or Update? □ No □Yes
_____

Since your last visit here, are there any other details of your health history that have changed? □ No □Yes

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Are you pregnant? □ No □Yes **Are you nursing? □ No □Yes**

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

REVIEW OF SYSTEMS

Name of Patient:_____ **Date Completed** _____

Please CHECK if you are experiencing any of the following symptoms

Health in general: □ Chills □Fatigue □Fever □Weight Gain □ Weight Loss
□ Other _____ □ NONE

Skin: □ excessive dryness □ itching □ skin lesion □rash (eczema, psoriasis, rosacea)
□ Other _____ □ NONE

Ears, Nose, Mouth, Throat: □ Sinus pain □ ear discharge □ ear pain □ hearing loss
□ tinnitus (ringing/buzzing/swoosh) □ nasal congestion □ nosebleeds □ rhinorrhea (runny nose)
□ hoarseness □ sore throat □Other _____ □ NONE

Cardiovascular: □ Chest pain □ claudication (leg pain/cramping) □ dyspnea on exertion (shortness of breath with effort) □ leg swelling □ orthopnea (shortness of breath while laying down) □ palpitations
□ Other _____ □ NONE

Respiratory: □ Cough □ hemoptysis (coughing up blood) □shortness of breath □ sputum production
□ wheezing □ sleep apnea (CPAP Y/N) □Other _____□ NONE

Gastrointestinal: □ Abdominal pain □ belching □ blood in stool □ constipation □ diarrhea
□ heartburn □ hemorrhoids □ nausea □ trouble swallowing □ vomiting
□ Other _____ □ NONE

Genitourinary: □ Irregular menses □ bladder incontinence □ polyuria(frequent urination)
□dysuria (painful urination) □ Other _____ □ NONE

Muscle, Joint and Bone: □ Back pain □ falls □ joint pain □ myalgia (muscle pain) □ neck pain
□ Other _____ □NONE

Neurological: □ Dizziness □ focal weakness □ headache □ loss of consciousness □ seizures
□ speech change □ numbness/tingling □ tremor □ Other_____ □ NONE

Psychiatric: □ Depression □ hallucinations □ insomnia □ memory loss □ nervous/anxious
□ Other _____ □ NONE

Allergic/ Immunology: □ Environmental allergies □ Other _____ □ NONE

Blood and Lymph: □ Easy bruise/ bleed □ lymph node swelling
□ Other _____ □ NONE

Glands and Endocrine: □ Hot flashes □ polydipsia (frequent thirst) □ excessive sweating
□ Other _____ □ NONE