CENTER FOR EYE & LASER SURGERY

Elba M. Pacheco, M.D., LLC

HEALTH QUESTIONNAIRE

PLEASE PRINT **Today's Date** ________________

Patient Name____**Sex: M F** **Date of Birth** ________________

Reason for your visit today (Please describe the details of your problem) ____

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PERSONAL MEDICAL HISTORY: Have you **ever** had any of the following conditions? Please circle YES or NO.

Condition		Condition	
Arthritis (other than back)	NO YES	Graves/Thyroid disease	NO YES
Cancer	NO YES	Heart disease	NO YES
Diabetes	NO YES	Hypertension	NO YES
Fever blisters/ Cold Sores	NO YES	Pacemaker/Defibrillator	NO YES
Glaucoma	NO YES	Sleep Apnea	NO YES

Details for YES responses from above and other medical conditions ____

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OPERATIONS (Include eye surgery) **Year**

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SOCIAL HISTORY

Marital Status: M S Sep W D

Occupation: ____

Smoking: NO YES__________________Packs per day

Alcohol: NO YES __________________Drinks per day

☐ Advised to stop smoking – Smoking Cessation counseling
10 minutes ___ 30 minutes ____

ALLERGIES:

Allergic to Latex: NO YES Medication Allergies: NO YES If YES, please list below and specify reaction

Medication Allergies:____

____

CURRENT MEDICATIONS (Include eye medications)

Name	Dose	Frequency	Reason

REVIEW OF HEALTH SYSTEMS: Please indicate any problems you have had in the **past six months**.

Please circle YES or NO.

CONSTITUTIONAL:	
Weight gain or loss-more than 10 lbs.	NO YES
Marked fatigue	NO YES
Unexplained night fever/sweats	NO YES
Migraine headaches	NO YES
EARS/NOSE/MOUTH/THROAT:	
Hearing loss or ringing in ears	NO YES
Chronic sinus problems or rhinitis	NO YES
Nose bleeds	NO YES
Swollen glands in neck	NO YES
CARDIOVASCULAR:	
Heart trouble	
Chest pain or angina pectoris	NO YES
Palpitation	NO YES
Shortness of breath with walking	NO YES
Swelling of feet or ankles	NO YES
RESPIRATORY:	
Chronic or frequent cough	NO YES
Spitting up blood	NO YES
Shortness of breath	NO YES
Asthma or wheezing	NO YES
GASTROINTESTINAL:	
Appetite changes	NO YES
Difficulty swallowing	NO YES
Frequent diarrhea or constipation	NO YES
Stomach ulcers	NO YES
GENITOURINARY:	
Blood in urine	NO YES
Female - irregular periods	NO YES
Male - prostate problems	NO YES
PSYCHIATRIC:	
Depression	NO YES
Psychosis	NO YES

INTEGUMENTARY (Skin, breast):	
Rash or itching	NO YES
Change in skin color/hair/nails	NO YES
Varicose veins	NO YES
Breast pain/lump/discharge	NO YES
MUSCULOSKELETAL:	
Joint stiffness or swelling	NO YES
Weakness in muscles or joints	NO YES
Back pain	NO YES
Cold extremities	NO YES
NEUROLOGICAL:	
Lightheadedness or dizziness	NO YES
Convulsions or seizures	NO YES
Numbness or tingling sensation	NO YES
Tremors	NO YES
Paralysis	NO YES
Stroke	NO YES
Head injury	NO YES
ENDOCRINE:	
Glandular or hormone disease	NO YES
Thyroid disease	NO YES
Diabetes	NO YES
HEMATOLOGIC/LYMPHATIC:	
Slow to heal after cuts	NO YES
Bleeding or bruising tendency	NO YES
Anemia	NO YES
Phlebitis	NO YES
Past transfusion	NO YES
Enlarged glands	NO YES
ALLERGIC/IMMUNOLOGIC:	
Atopic disease	NO YES
Rheumatoid pain	NO YES
Dry eye, dry mouth	NO YES

If YES, please explain ____

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____

FAMILY HISTORY **(please indicate relation, i.e., father, mother, grandfather, grandmother, siblings, children)**

Cancer________________________

Diabetes________________________

Heart disease________________________

Hypertension________________________

Thyroid________________________

Glaucoma________________________

Macular degeneration________________________

Retinal detachment________________________

Droopy lids ________________________

Other inherited eye condition________________________

Other (specify) ____

____

Any other information of which the doctor should be aware ________________________

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PHYSICIAN USE ONLY: Reviewed by________________________Date________________

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