

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) _____

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

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 _____

OPERATIONS (Include eye surgery)

Year

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 _____

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 _____

PHYSICIAN USE ONLY: Reviewed by _____ Date _____