Name: **Date:** / /

Medical and Family History: Please check (✓) the following if they apply to yourself (S) or to your family members (F).

S	F		S	F		S	F	
		Anemia			Emphysema			Kidney Disease
		Arthritis			Gout			Seizures
		Asthma			Heart Attack			Stroke
		Cancer			Hepatitis			Thyroid Disease
		Diabetes (_____#yrs)			High Blood Pressure			Vascular Disease

Other Medical Problems (such as)**:**
- ❏ Hepatitis
- ❏ Other___________________
- ❏ Sexually Transmitted Disease
- ❏ Tuberculosis
- ❏ HIV

Previous Surgery (non-eye surgery): Please give approximate dates ❏ no prior surgery

Previous Injuries: Please give approximate dates

Treatments or Hospitalizations: Please give approximate dates

Medications (non-eye medications, include nonprescription drugs): ❏ no medications

Allergies and Drug Reactions ❏ no allergies

Social History: Circle answer

Do you drink alcohol?	No	Yes	(if yes explain)________________
Do you smoke?	No	Yes	(if yes explain)________________
Any use of “street drugs”?	No	Yes	(if yes explain)________________
Do you live alone?	No	Yes	
Do you drive?	No	Yes	

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

PATIENT HISTORY QUESTIONNAIRE

Medical Record Form 7742–11/05
The University of Texas Medical Branch Hospitals
Galveston, Texas

UTMB FORMS MGT. STRICTLY PROHIBITS CHANGES TO THIS FORM

Name: **Date:** / /

Review of Systems: If you are currently having any problems in the following areas, please circle and explain.

Skin: itching, rash, infection, ulcer, tumors (growths), other ❏ none

Lymph nodes: swelling, tenderness, other ❏ none

Bones, Joints, Muscles: muscle pain/cramps, joint pain/swelling, other ❏ none

Endocrine: fatigue, confusion, fainting, nervousness, hot/cold intolerance, hair loss, other ❏ none

Allergy/Immunology: recurrent infections, hay fever, hives, food allergy, drug sensitivity, other ❏ none

Head: headaches, dizziness, vertigo, other ❏ none

Ears: hearing loss, ringing, infections, other ❏ none
Nose: bleeding, loss of smell, congestion, sinus problems, other ❏ none
Throat: dry mouth, loss of taste, difficulty swallowing, hoarseness, other ❏ none

Neck: pain, swelling, stiffness, other ❏ none

Breasts: tenderness, swelling, lumps, discharge, other ❏ none

Blood: fever/chills, bruise easily, prolonged bleeding, skin hemorrhages, blood loss, other ❏ none

Respiratory: wheezing, cough (productive/blood), difficulty breathing, asthma, other ❏ none

Cardiovascular: (heart/blood vessels): chest pain, swelling of extremities, shortness of breath, exercise intolerance, other ❏ none

Gastrointestinal: (stomach/intestines): nausea, vomiting, change in bowel habits, constipation, diarrhea, pain/cramps, bleeding, other ❏ none

Genitourinary: (genitals/kidney/bladder): frequency, burning, hesitancy, pain or bleeding on urination, infections, incontinence, impotence, other ❏ none

Nervous System: weakness in arms or legs, numbness or tingling, loss of consciousness, falls, difficulty walking, seizures, tremors, neuralgia, other ❏ none

Psychiatric: disorientation, mood swings, anxiety, depression, hallucinations, other ❏ none

This form completed by (circle): Patient Family Staff

History reviewed by ______________________________ M.D. Date______________