PATIENT MEDICAL HISTORY QUESTIONNAIRE

NAME **(Non)**: ______________________________ MR # ______________________ Date **(Dat)**: ____________

Date of Birth (**Dat nesans**): ______________ Age (**Laj**):____ ☐ Male (**Gason**) ☐ Female (**Fi**)

Weight (**Pwa**): ________ Height (**Tay**): ______

PLEASE CHECK BOX IF THE ANSWER IS YES TO ITEMS BELOW
TANPRI TCHEKE TI KARE Si repons lan se WI POU ATIK ANBA

☐ **Katarat** (Cataracts)
☐ **Glokòm** (Glaucoma)
☐ **Maladi retin** (Retinal Disorders)
☐ **Retinopati Dyabetik** (Diabetic Retinopathy)
☐ **Dejeneresans Makulèr** (Macular Degeneration)
☐ **Pwoblèm Kornin** (Corneal Problems)

FAMILY ISTWA (FAMILY HISTORY):

☐ **Kansè** (Cancer)
☐ **Glokòm** (Glaucoma)
☐ **Dyabèt** (Diabetes)
☐ **Dejeneresans Makulèr** (Macular Degeneration)
☐ **Tansyon wo** (Hypertension)
☐ **Maladi kè** (Heart Disorders)
☐ **Maladi retin** (Retinal Disorders)

PLEASE CHECK BOX IF YOU HAVE ANY OF THE FOLLOWING HEALTH CONDITIONS:

TANPRI TCHEKE BWAT SI OU GEN NENPÒT NAN KONDISYON SA YO SANTE YO

☐ **Kadyo-vaskilè** (Cardiovascular)
- ☐ **Kè, atak kadyak** (Heart Attack)
- ☐ **Anjin** (Angina)
- ☐ **Konjesyon Serebral** (Stroke)
- ☐ **Tansyon wo** (High Blood Pressure)
- ☐ **Pesmekè / defibrilate** (Pacemaker/Defibrillator)
- ☐ **Kè bougonnen** (Heart Murmur)
- ☐ **Lòt** (Other): ________________

☐ **Segondè Kolestewòl** (High Cholesterol)
☐ **Newolojik / Sikyatrik**
(Congestion)
(Neurologic/Psychiatric)
- ☐ **Kriz / kriz** (Seizures/convulsion)
- ☐ **Parkinson la** (Parkinson's Disease)

☐ **Alzayme a** (Alzheimer's)
☐ **Anksyete** (Anxiety)
- ☐ **Depresyon** (Depression)
- ☐ **Lòt** (Other): _____________
____

☐ Andokrin (Endocrine)
- ☐ **Dyabèt** (Diabetes)
- ☐ **Tiwoyid** (Thyroid)
- ☐ **Lòt** (Other):
____

☐ **Ematolojik** (Hematologic)
- ☐ Anemi (Anemia)
- ☐ Senyen / kraze fasil (Bleed/bruise easily)
- ☐ **Lòt** (Other):
____

☐ **Mis** (Musculoskeletal)
- ☐ **Atrit** (Arthritis)
- ☐ **Ranplasman Joint** (Joint Replacement)
- ☐ **Lòt** (Other):
____

☐ **Zòrèy/Nen/gòj** (ENT)

☐ **Nan vant/entesten**
Stomach/intestinal
- ☐ **Maladi ilsè** (Ulcers)
- ☐ **Kolit** (Colitis)
- ☐ **Lòt** (Other):
____

☐ **Respiratwa** Respiratory
- ☐ Opresyon Asthma
- ☐ COPD
- ☐ Tibèkiloz Tuberculosis
- ☐ Dòmi apne
- ☐ **Lòt** Other:
____

☐ **Kansè** (Cancer)
____

☐ **Pwoblèm Po** (Skin)
____

☐ **oftalmolojik andigman**
Ocular Surface Disease
- ☐ **Je grate** (Itchy eyes)
- ☐ **je Wouj** (Red eyes)
- ☐ **je Dlo** (Watery eyes)
- ☐ **je Anfle** Swollen eyes
- ☐ **je Sèk** (Dry eyes)
- ☐ **Etranje kò sansasyon** (Foreign Body Sensation)

☐ **Lòt Alèji Sentòm** (Add'l Allergy Symp)
- ☐ **Anbouteyaj**
- ☐ **Nen k ap koule** (Runny Nose)
- ☐ **Ti sèk nwa anba je** (Dark circles under eyes)
- ☐ **Grate po toke** (Itchy Flaky Skin)

Èske ou fè alèji ak nenpòt medikaman (ki gen ladan yòd)? ☐ Wi ☐ Pa gen Si wi, tanpri lis medikaman ak reyaksyon:
____

Èske ou fè alèji ak latèks? ☐ Wi ☐ Pa gen Si wi, tanpri lis reyaksyon : ______________________

Je Operasyon / soufri chòk aprè yon: Tanpri Ekri: je dwa______________________________
je gòch______________________________

Operasyon / Ospitalizasyon / Pwosedi: ______________________________
____

Istwa sosyal: ☐ fimen ☐ Kite fimen – ane:_____ ☐ alkòl ☐ k ap viv pou kont li ☐ Viv ak lòt
Rekreyatif itilizasyon dwòg ☐ Wi ☐ Pa gen
Jwèt ______________________________

Prensipal Doktè Swen:______________________________

Lekòl la ______________________ eta ____ Telefòn.________________

Pharmacy: ____________________ Location: ________________ PH: ____________________

EYE CENTERS OF FLORIDA **PATIENT MEDICAL HISTORY QUESTIONNAIRE**

Non ______________________________________ **Acct#**___________________ **Dat** ________________________

Tanpri fè lis tout medikaman w ap pran ENKLI Kounye a Eyedrops & VITAMIN

Medikaman	fòs	Chak kile	Office Use Only	Medikaman	fòs	Chak kile	Office Use Only

Siyati (Pasyan / Paran / Gadyen / Konsèvatè)**:**_______________________________________ **Dat** _____________

Si lòt pase pasyan, tanpri endike relasyon: __________________________________

Office Use Only

Reviewed by: ______________________________________ Date ____________________

UPDATES:

Reviewed by: ____________________/____________________ Date: _________________ [ ] Updated [ ] No change
Reviewed by: ____________________/____________________ Date: _________________ [ ] Updated [ ] No change
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