Ophthalmology Consultants of Fort Wayne, P.C.

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MEDICAL HISTORY QUESTIONNAIRE

Patient Name _____ Date of Birth _____

Who is your Primary Care Physician? _____

Who Referred you to our Office? _____

Reason for Today's Visit? _____

Medication Allergies And Reactions _____

Employer/Occupation _____

Emergency Contact _____ Phone _____

REVIEW OF SYSTEMS - DO YOU CURRENTLY HAVE OR HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING?

SYSTEM	YES / NO
Constitutional: Fever	☐ Yes ☐ No
Weight: ☐ Loss ☐ Gain	☐ Yes ☐ No
Eyes: Double vision	☐ Yes ☐ No
Sensitivity to light	☐ Yes ☐ No
Pain	☐ Yes ☐ No
Floaters	☐ Yes ☐ No
ENT: Hearing loss	☐ Yes ☐ No
Sinus problems	☐ Yes ☐ No
Sore throat	☐ Yes ☐ No
Respiratory: Asthma	☐ Yes ☐ No
Cough	☐ Yes ☐ No
Cardiovascular: Chest pressure or discomfort	☐ Yes ☐ No
Irregular heartbeat/palpitations	☐ Yes ☐ No
Gastrointestinal: Diarrhea	☐ Yes ☐ No
Heartburn	☐ Yes ☐ No
Vomiting	☐ Yes ☐ No
Genitourinary: Kidney stones	☐ Yes ☐ No

SYSTEM	YES / NO
Metabolic: Intolerant to: ☐ Heat ☐ Cold	☐ Yes ☐ No
Endocrine: Excessive thirst	☐ Yes ☐ No
Urinating more often	☐ Yes ☐ No
Neurological: Weakness	☐ Yes ☐ No
Headache	☐ Yes ☐ No
Numbness of Extremities	☐ Yes ☐ No
Psychiatric: Depressed mood	☐ Yes ☐ No
Integumentary/Skin: Dry skin	☐ Yes ☐ No
Rash	☐ Yes ☐ No
Musculoskeletal: Arthritis	☐ Yes ☐ No
Joint swelling	☐ Yes ☐ No
Hematologic/Lymphatic:	☐ Yes ☐ No
Easily: ☐ Bleeds ☐ Bruises	☐ Yes ☐ No
Swollen lymph nodes	☐ Yes ☐ No
Allergic/Immunologic:	☐ Yes ☐ No
☐ Environmental ☐ Food ☐ Seasonal	☐ Yes ☐ No

List all prescribed and over the counter medications, including supplements you are taking:

NAME	FOR WHAT CONDITION	DOSAGE	FREQUENCY