

TEXAS EYE PHYSICIANS, P.A.
HUY M. TRAN, M.D.
DIPLOMATE OF THE AMERICAN BOARD OF OPHTHALMOLOGY
101 W. RANDOL MILL RD. STE 120 ARLINGTON, TX 76011
PATIENT HISTORY QUESTIONNAIRE PAGE 2

NAME: _____ **DATE:** _____

REVIEW OF SYSTEMS: *If you are currently having any problems in the following areas, please circle.*

- SKIN: itching, rash, 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, jaw pain, other ◇ none
- NECK: pain, swelling, stiffness, other ◇ none
- BREASTS: tenderness, swelling, lumps, discharge, other ◇ none
- BLOOD: fever, chills, bruise easily, prolonged bleeding ◇ 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, palpitations, other ◇ none
- GASTROINTESTINAL (stomach, intestines): nausea, vomiting, change in bowel habits, constipation, diarrhea, pain, cramps, bleeding, other ◇ none
- GENITOURINARY: 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

SOCIAL HISTORY:

Do you smoke? YES NO (if yes, how much?) _____
 Do you drink? YES NO (if yes, how much?) _____
 Any use of "street drugs"? YES NO
 Do you drive? YES NO
 What hobbies do you enjoy? _____