

MICHAEL J. HAWES, M.D.

PATIENT HEALTH QUESTIONNAIRE

Date _____

PATIENT'S NAME _____

ALLERGIES Do you have allergies to medicines? Yes ___ No ___

Please list: _____

MEDICATIONS Are you taking any medications? Yes ___ No ___

Please list: _____

PAST MEDICAL HISTORY

Have you had any medical problems? Yes ___ No ___

Please list: _____

Have you had any surgeries? Yes ___ No ___

<u>Type of Surgery</u>	<u>Date</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Have you ever had a blood transfusion? Yes ___ No ___

What year? _____

FAMILY HISTORY Any family history of eye disease? Yes ___ No ___

Please list: _____

Any diseases that run in your family? Yes ___ No ___

Please list: _____

SOCIAL HISTORY

Do you use tobacco products? Yes___ No___
If yes, for how many years:_____

Do you drink alcoholic beverages? Yes___ No___

Has drinking been a problem for you? Yes___ No___

SYSTEM REVIEW

Do you now have or have you experienced:

No

Yes

___	Skin problems	___
___	Seizures	___
___	Dentures	___
___	Trouble swallowing	___
___	Thyroid trouble	___
___	Hearing loss	___
___	Shortness of breath	___
___	Chronic cough	___
___	Asthma, emphysema	___
___	Heart attack	___
___	Chest pain	___
___	Ankle swelling	___
___	Chronic constipation	___
___	Chronic diarrhea	___
___	Kidney stones	___
___	Chronic burning on urination	___
___	Arthritis	___
___	Diabetes	___
___	High blood pressure	___
___	Bleeding disorder	___
___	Depression, mental illness	___

PATIENT SIGNATURE_____