

PERSONAL INFORMATION AND HEALTH HISTORY
BAYLOR NEURO-OPHTHALMOLOGY SERVICE

Dear Patient:

Thank you for taking the time to complete this questionnaire. This information will be reviewed by the doctor with you and will help him/her to understand your past medical history and present concerns. The information will be part of your medical record and will be revealed only to your physicians and person that you designate. Please answer all questions carefully and completely, as the information is very important to your care. If you were sent this form in the mail, please bring it with you at the time of your office visit.

PERSONAL INFORMATION

Name _____

Address _____

Home Telephone _____ Work Telephone _____

Age _____ Date of Birth _____ Sex M F SS# _____

Mother's first name _____ Father's first name _____

REFERRING PHYSICIAN INFORMATION

Please give the name of the physician who referred you to us. If a physician did not refer you, then indicate how you found out about us:

Referring Physician	Address	City	State	Zip Code	Telephone
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Please give the name and address of other physicians that you would like to receive a copy of the report from today's visit:

Physician's Name	Address	City	State	Zip Code	Telephone
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Physician's Name	Address	City	State	Zip Code	Telephone
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REASON FOR NEURO-OPHTHALMIC EVALUATION

Please explain in your own words, the nature of the difficulty that you are experiencing. Please be as specific as you can. (For example: *I lost the vision of my right eye four days ago - or - I have double vision that is worse at the end of the day, etc.*)

**CONSENT FOR RELEASE OF INFORMATION
AND / OR PHOTOGRAPHS / VIDEOTAPING
BAYLOR NEURO-OPHTHALMOLOGY SERVICE**

Date: _____

I, the undersigned, give Rod Foroozan, M.D. permission to interview, photograph or videotape _____ . I also give Rod Foroozan, M.D. permission to use the photographs / videotape / information in anyway the doctor deems proper. This includes, but is not limited to, still or motion picture, newspapers, magazines, or other printed media, as well as broadcast by means of radio or television transmission.

I give Rod Foroozan, M.D. rights, title, and interest in the photographs, negatives, reproductions and copies of original prints and negatives taken of me. I also give Rod Foroozan, M.D. the right to give these negatives, original prints, original videotapes or copies of original prints, original videotapes and negatives to any news media for lawful use.

I have read the forgoing and I completely understand its meaning. Any questions that I had were answered to my satisfaction. I also understand that regardless of the use of the photographs / videotapes, I am not entitled to any royalties, payment or any other type of remuneration.

Signature _____

Address _____

REVIEW OF SYSTEMS

Please indicate if you currently have or have had any of the listed conditions. Please indicate when the condition began where appropriate. Space has been provided for an additional description if needed.

1. General (Constitutional)	No	Yes	Description
Weight changes _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic fatigue _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fever _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Night Sweats _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

2. Neurologic			Description
Frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of consciousness _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with balance _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke / Mini Stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech trouble _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weakness of arms _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weakness of legs _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Numbness / tingling _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brain tumor _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brain hemorrhage _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure / epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

3. Cardiovascular			Description
Heart Attack _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart failure _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irregular heart beat _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Palpitations _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pain _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart surgery _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pacemaker _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

REVIEW OF SYSTEMS

4. Respiratory	No	Yes	Description
Wheezing _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of Breath _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coughing up blood _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

5. Musculoskeletal			Description
Jaw pain with chewing _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle Aches _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint pain _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Herniated Discs _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Broken bones _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone surgery _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

6. Gastrointestinal			Description
Nausea _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vomiting _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry mouth _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty swallowing _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Heartburn _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diarrhea _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rectal bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

7. Dermatologic			Description
Scalp tenderness _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rashes _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psoriasis _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other skin conditions _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

REVIEW OF SYSTEMS

8. Eye	No	Yes	Description
Double vision _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of vision _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye surgery _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

9. Ears / Nose / Throat			Description
Hearing loss _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ringing in ears _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent sore throat _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus allergies _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

10. Kidney / Urinary			Description
Bladder problems _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney problems _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary infections _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prostate problems _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

11. Blood / Lymphatic			Description
Bleeding problems _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Easy bruising _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Clotting problems _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Embolism _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood disorders _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sickle-Cell disease _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Leukemia _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen glands _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

12. Psychiatric			Description
Severe depression _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suicidal thought _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental illness _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

REVIEW OF SYSTEMS

13. Infections

	No	Yes	Description
Sexually transmitted _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

14. Endocrine

	No	Yes	Description
Thyroid disease _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hormone problems _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

15. Cancer

	No	Yes	Description
Cancer of any kind _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Radiation treatment _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer surgery _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

16. Gynecologic

	No	Yes	Description
Are you pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Miscarriages _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Menstrual Period _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Regular _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heavy bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Menopause _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

PREVIOUS MEDICAL HISTORY

Have you ever been diagnosed with any of the following conditions:

	No	Yes	
Diabetes_____	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness_____ <input type="checkbox"/> No <input type="checkbox"/> Yes
High blood pressure_____	<input type="checkbox"/>	<input type="checkbox"/>	
Heart disease_____	<input type="checkbox"/>	<input type="checkbox"/>	Please list any others
Cancer_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list all previous surgeries (including eye surgery):

Type of surgery	Hospital	Month	Year
1. _____			
2. _____			
3. _____			
4. _____			

Please list all previous hospitalizations and reason for hospitalization:

Reason for hospitalization	Hospital	Month	Year
1. _____			
2. _____			
3. _____			
4. _____			

SOCIAL HISTORY

Occupation_____ Marital status_____

Highest level of education_____ Children_____

Do you have a driver's license_____ Who lives with you?_____

Do you use tobacco products? If so, how much and for how long?_____

Have you ever used or are currently using any drugs not prescribed by a physician, including any type of "street drugs"?_____

Have you ever been under the care of a mental health professional?_____

FAMILY HISTORY

Does anyone in your family have any of the following conditions:

	No	Yes	Family Member	Age
Diabetes_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High blood pressure_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart disease_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cancer_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Glaucoma_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Migraines_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Blindness_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental Illness_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Please list any other diseases in your family: _____

MEDICATIONS

Please list all of the medications you are currently using:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Do you have any allergies?

	No	Yes	What happens
Medications_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dyes / Contrast Agents_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seasonal_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Is there any additional information which you feel would be important for the doctor to know. Please provide that information. _____

Thank you for taking time to provide the above information. The doctor will discuss these and other health concerns with you during your examination.

Signature _____ Date _____