

PATIENT HEALTH HISTORY

Patient Name: _____ DOB ____/____/____ Gender: M F Today's Date: ____/____/____

Address: _____

Home Phone#: _____ Cell Phone#: _____ Work Phone#: _____

E-mail Address: _____ Social Security # _____ - _____ - _____

Primary Care Physician: _____ Date Last Seen: _____ Occupation: _____

Medical/Family History (use back sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins and herbal therapy): _____

List all major surgeries (Eye Surgery included): _____

List any allergic reactions to **medications or eye drops**: _____

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition

Yourself

Yes No

- Cataract Yes No
- Eye Turn Yes No
- Glaucoma Yes No
- Macular Degeneration Yes No
- Retinal Detachment Yes No

- Women- Are you pregnant? Yes No
- Are you breast feeding? Yes No

Family Member

Yes No

- Blindness Yes No
- Eye Turn Yes No
- Glaucoma Yes No
- Macular Degeneration Yes No
- Retinal Detachment Yes No

Relationship (Blood Relatives Only)

Other: _____

Review of Systems

Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic

- None
- Lupus (SLE)
- Rheumatoid Arthritis
- Environmental Allergies
- Seasonal Allergies
- Other (i.e., Latex)

Ear, Nose and Throat

- None
- Sinusitis
- Upper Respiratory Tract Infection
- Other

Gastrointestinal

- None
- Crohn's Disease
- Colitis
- Acid Reflux/Ulcer
- Other

Skin / Integumentary

- None
- Eczema
- Rosacea
- Psoriasis
- Other

Psychiatric

- None
- Depression
- Bi-Polar
- Schizophrenia
- Other

Cardiovascular

- None
- High Blood Pressure
- Heart Disease
- Stroke
- Vascular Disease
- High Blood Cholesterol

Endocrine/Glands

- None
- Diabetes
- Hormone Dysfunction
- Thyroid Dysfunction
- Other

Respiratory

- None
- Asthma
- Bronchitis
- Emphysema
- Other

Muscle/Skeletal

- None
- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis
- Other

Genital/Urinary

- None
- Urinary Tract Infection
- HIV Positive
- Herpes/Chlamydia
- Other

Hematologic/Lymphatic

- None
- Anemia
- Leukemia
- Bleeding Disorder
- Other

Neurological

- None
- Multiple Sclerosis
- Epilepsy
- Tremors
- Other

General Health

- None
- Weight loss/gain
- Fever
- Fatigue
- Trauma

Social

- Tobacco Use:
Current Smoker _____ Former Smoker _____
- Non-Prescription Drugs _____
- Alcohol Consumption _____
- Weight _____ Height _____

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____ Reviewed by Doctor's initials: _____

Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____