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	☐	☐
Eye Turn	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐

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

	Family Member Yes	No	**Relationship (Blood Relatives Only)**
Blindness	☐	☐	_____
Eye Turn	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____

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

Please sign below to acknowledge that this form is current:

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