PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

Medical Information: Check the medical conditions that apply to you and/or your family

☐Self ☐Family Allergy/Immunologic (allergies, sinusitis)
☐Self ☐Family Cardiovascular (Heart, Blood Pressure, Stroke)
☐Self ☐Family Constitutional (Fatigue, nausea, thirst)
☐Self ☐Family Endocrine (Cholesterol, diabetes, thyroid)
☐Self ☐Family Ears/Nose/Throat/Mouth (dry mouth)
☐Self ☐Family Gastrointestinal (Colitis, ulcer, Crohn's)
☐Self ☐Family Genitourinary (Kidney, bladder, syphilis, STD)
☐Self ☐Family Hematologic/Lymphatic (anemia, Breast Carcinoma)
☐Self ☐Family Integumentary/Skin (Rosacea, lupus, psoriasis)
☐Self ☐Family Musculoskeletal (skeletal, arthritis, myasthenia gravis)
☐Self ☐Family Neurologic (Bell's palsy, brain tumor, headache)
☐Self ☐Family Psychiatric (ADD, learning disability, bi-polar)
☐Self ☐Family Respiratory (Asthma, COPD, emphysema)
☐Self ☐Family Developmental (Premature, autism, delayed)

Explain any of the above checked:_____

List other medical problems: _____

Who is your primary physician? : _____

Other Doctors you visit: _____

Date of Last Physical Examination: _____ If you were referred here by your doctor, give

the reason:_____

Are you allergic to any medicines? List: _____

Do you use: Tobacco? ☐Y ☐N Alcohol? ☐Y ☐N Other Substances? ☐Y ☐N Height _____ft_____in Weight _____lbs

Do you have a history of: STD? ☐ Y ☐ N Blood Transfusions? ☐ Y ☐ N

Surgeries (List type and date) : _____

_____

Eye & Vision History: check the eye conditions that apply to you and/or your family.

☐Self ☐Family Amblyopia (lazy eye)
☐Self ☐Family Blindness
☐Self ☐Family Light Sensitivity
☐Self ☐Family Cataracts
☐Self ☐Family Color Blindness
☐Self ☐Family Diabetic retinopathy
☐Self ☐Family Eye Pain
☐Self ☐Family Dry Eyes
☐Self ☐Family Eye infections
☐Self ☐Family Head Trauma
☐Self ☐Family Eyestrain
☐Self ☐Family Glaucoma
☐Self ☐Family Flashing lights
☐Self ☐Family Red Eyes
☐Self ☐Family Floaters/spots in vision
☐Self ☐Family Eye Injury
☐Self ☐Family Vision comes and goes
☐Self ☐Family Macular Degeneration
☐Self ☐Family Retinal Detachment
☐Self ☐Family Strabismus (crossed eye)
☐Self ☐Family Blind Spot in Vision

Have you had eye surgery? ☐ Y ☐ N Please explain: _____
Any eye problems at this time? Please explain: _____

Do you take any medications including eye drops? List: _____

_____

What is the reason for your visit today? _____