PATIENT HEALTH HISTORY

Patient Name: _____ DOB___/___/___ Gender: M F I am: Right-handed Left -handed

Primary Care Physician: _____ Date Last Seen: _____

Medical/Family History

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

_____

_____

List all major surgeries (Eye Surgery included): _____

_____

_____

List allergic conditions: (medications, seasonal, mold, dust, latex, eye drops): _____

_____

_____

Please indicate if any of the conditions apply to you or a family member:

Disease/Condition	Yourself		Family Member		Relationship (Blood Relatives Only)
Cataract	Yes	No	Yes	No	_____
Eye Turn	Yes	No	Yes	No	_____
Glaucoma	Yes	No	Yes	No	_____
Macular Degeneration	Yes	No	Yes	No	_____
Retinal Detachment	Yes	No	Yes	No	_____
Other			Yes	No	_____

Women: Are you Pregnant? Yes No

Women: Are you Nursing? Yes No

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
Other _____

Ear, Nose and Throat
None
Sinusitis
Upper Respiratory Tract Infection
Other _____

Gastrointestinal
None
Crohn's Disease
Colitis
Acid Reflux/Ulcer
Other _____

Skin
None
Eczema
Rosacea
Psoriasis
Other _____

Psychiatric
None
Depression
Anxiety
Bi-Polar
Other _____

Cardiovascular
None
High Blood Pressure
Heart Disease
Stroke
Vascular Disease

Endocrine/Glands
None
Diabetes
Hormone Dysfunction
Thyroid Dysfunction
Other _____

Respiratory
None
Asthma
Bronchitis
Emphysema
Other _____

Muscle/Skeletal
None
Arthritis
Fibromyalgia
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
Previous Smoker
Non-Prescription Drugs
Alcohol Consumption _____
Weight_____ Height_____

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____