

# 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:**

<b>Disease/Condition</b>	<b>Yourself</b>				
Cataract	Yes	No	Women: Are you Pregnant?	Yes	No
Eye Turn	Yes	No	Women: Are you Nursing?	Yes	No
Glaucoma	Yes	No			
Macular Degeneration	Yes	No			
Retinal Detachment	Yes	No			
	<b>Family Member</b>		<b>Relationship (Blood Relatives Only)</b>		
Cataract	Yes	No	_____		
Eye Turn	Yes	No	_____		
Glaucoma	Yes	No	_____		
Macular Degeneration	Yes	No	_____		
Retinal Detachment	Yes	No	_____		
Other	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 \_\_\_\_\_

### Cardiovascular

None  
High Blood Pressure  
Heart Disease  
Stroke  
Vascular Disease

### Hematologic/Lymphatic

None  
Anemia  
Leukemia  
Bleeding Disorder  
Other \_\_\_\_\_

### Ear, Nose and Throat

None  
Sinusitis  
Upper Respiratory  
Tract Infection  
Other \_\_\_\_\_

### Endocrine/Glands

None  
Diabetes  
Hormone Dysfunction  
Thyroid Dysfunction  
Other \_\_\_\_\_

### Neurological

None  
Multiple Sclerosis  
Epilepsy  
Tremors  
Other \_\_\_\_\_

### Gastrointestinal

None  
Crohn's Disease  
Colitis  
Acid Reflux/Ulcer  
Other \_\_\_\_\_

### Respiratory

None  
Asthma  
Bronchitis  
Emphysema  
Other \_\_\_\_\_

### General Health

None  
Weight loss/gain  
Fever  
Fatigue  
Trauma

### Skin

None  
Eczema  
Rosacea  
Psoriasis  
Other \_\_\_\_\_

### Muscle/Skeletal

None  
Arthritis  
Fibromyalgia  
Other \_\_\_\_\_

### Social

Tobacco Use: Current Smoker  
Previous Smoker  
Non-Prescription Drugs  
Alcohol Consumption \_\_\_\_\_  
Weight \_\_\_\_\_ Height \_\_\_\_\_

### Psychiatric

None  
Depression  
Anxiety  
Bi-Polar  
Other \_\_\_\_\_  
**Genital/Urinary**  
None  
Urinary Tract Infection  
HIV Positive  
Herpes/Chlamydia  
Other \_\_\_\_\_

**Please sign below to acknowledge that this form is current:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_