Patient Health History

Personal Information

Name _____ Date of Birth ___/___/___ Sex M F

Height _____ Weight _____ Hand Preference (e.g. Left, Right) _____

Primary Care Physician & Approximate Date Last Seen _____

Medical / Family History

Please list all of 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 these conditions apply to **YOU**:

- ❑ Cataract
- ❑ Eye Turn
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Other: _____

Please indicate if any of these conditions apply to **a Family Member**:

- ❑ Cataract
- ❑ Eye Turn
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Other: _____

Women:

- ❑ Are you pregnant?
- ❑ Are you nursing?

Social History

Please indicate your current status below:

Tobacco Use

- ❑ Never Smoked
- ❑ Former Smoker
- ❑ Current Everyday Smoker
- ❑ Current Some Day Smoker
- ❑ Heavy Tobacco Smoker
- ❑ Light Cigarette Smoker (1-9 cigs / day)
- ❑ Current Smokeless Tobacco User
- ❑ Current Vape / E-Cig User

Alcohol Use

- ❑ None
- ❑ Social Use Only
- ❑ 1-2 drinks daily
- ❑ More than 2 drinks daily

Narcotic Use

- ❑ None
- ❑ Recreational Use
- ❑ Medical Use

Review of Systems

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

Allergy
- ❑ No Concerns
- ❑ Yes - See details listed above

Cardiovascular
- ❑ No Concerns
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Stroke
- ❑ Other: _____

Constitutional (General Health)
- ❑ No Concerns
- ❑ Dizziness
- ❑ Fatigue
- ❑ Fever
- ❑ Weight loss / gain
- ❑ Other: _____

Endocrine
- ❑ No Concerns
- ❑ Cholesterol (Elevated)
- ❑ Crohn's Disease
- ❑ Diabetes
- ❑ Pituitary Disorder
- ❑ Thyroid Disorder
- ❑ Other: _____

Gastrointestinal
- ❑ No Concerns
- ❑ Acid Reflux
- ❑ Colitis
- ❑ Ulcer
- ❑ Other: _____

Genitourinary
- ❑ No Concerns
- ❑ Kidney Stones
- ❑ Prostate Disorder
- ❑ STI (Chlamydia, Syphilis, etc.)
- ❑ Other: _____

Head
- ❑ No Concerns
- ❑ Chronic Cough
- ❑ Dry Mouth
- ❑ Headaches
- ❑ Migraines
- ❑ Ringing Ears
- ❑ Sinusitis
- ❑ Trauma
- ❑ Other: _____

Hematologic / Lymphatic
- ❑ No Concerns
- ❑ Anemia
- ❑ Bleeding Disorder
- ❑ Breast Cancer
- ❑ Hodgkin's Disease
- ❑ Leukemia
- ❑ Other: _____

Immunologic
- ❑ No Concerns
- ❑ AIDS
- ❑ Chicken Pox
- ❑ Herpes Simplex (Cold Sores)
- ❑ Herpes Zoster (Shingles)
- ❑ Lyme Disease
- ❑ Other: _____

Integumentary (Skin)
- ❑ No Concerns
- ❑ Acne
- ❑ Acne Rosacea
- ❑ Eczema
- ❑ Lupus
- ❑ Psoriasis
- ❑ Other: _____

Musculoskeletal
- ❑ No Concerns
- ❑ Arthritis
- ❑ Fibromyalgia
- ❑ Osteoporosis
- ❑ Rheumatoid Arthritis
- ❑ Other: _____

Neurological
- ❑ No Concerns
- ❑ Blackouts
- ❑ Dyslexia
- ❑ Epilepsy
- ❑ Fainting
- ❑ Multiple Sclerosis
- ❑ Seizures
- ❑ Tremors
- ❑ Other: _____

Psychiatric
- ❑ No Concerns
- ❑ Alzheimer's Disease
- ❑ Anxiety
- ❑ Attention Disorder (ADD)
- ❑ Autism
- ❑ Bi-Polar Disorder
- ❑ Depression
- ❑ Other: _____

Respiratory
- ❑ No Concerns
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Lung Cancer
- ❑ Smoker
- ❑ Tuberculosis
- ❑ Other: _____

Signature: _____ Date: _____