Patient Health History Form

Name:_____ Today's Date:_____
Address:_____ Home Phone:_____
_____Work Phone :_____
E-Mail: _____ Cell Phone_____
Age: __ Birth Date: _____ SSN:_____ Occupation:_____
Last Eye Exam:_____ Name of Medical Doctor:_____ Dr's Phone:_____

Medical History

Do you have any allergies to any medications? Y N If so, explain: _____

List any medications you take (including oral contraceptives, aspirin, over-the-counter and home remedies):
_____
_____
_____

List all major injuries, surgeries, and/or hospitalizations:
_____
_____

Check any of the following that you have had:
□ Crossed eyes □ Lazy eye □ Drooping eyelid □ Prominent eyes □ Glaucoma □ Retinal disease □ Cataracts □ Eye infections □ Eye injury □ Other: _____

Are you pregnant and/or nursing? □ Yes □ No

Do you wear glasses? □ Yes □ No If yes, how old is your present pair of lenses?_____
Do you wear contact lenses? □ Yes □ No If yes, how old is your present pair of lenses?_____
Type of contact lenses: □ RGP □ Soft □ Extended Wear □ Other Are they comfortable? □ Yes □ No

Family History

Please note any family members (parents, grandparents, siblings, living or deceased) for the following conditions if applicable:

Disease / Condition	Yes	No	Relationship to you
Blindness	□	□	_____
Cataracts	□	□	_____
Crossed Eyes	□	□	_____
Glaucoma	□	□	_____
Macular Degeneration	□	□	_____
Retinal Detachment / Disease	□	□	_____
Arthritis	□	□	_____
Cancer	□	□	_____
Diabetes	□	□	_____
Heart Disease	□	□	_____
High Blood Pressure	□	□	_____
Kidney Disease	□	□	_____
Lupus	□	□	_____
Thyroid Disease	□	□	_____
Other:_____			_____

**** Please Turn This Form Over And Complete Side Two ****

Social History (This information is kept strictly confidential.)

Do you drive? □ Yes □ No If yes, do you have any visual difficulty when driving? □ Yes □ No If yes, please describe:
_____

Do you use tobacco products? □ Yes □ No If Yes, type/ amount/ how long:_____
Do you drink alcohol? □ Yes □ No If yes, type/ amount/ how long:_____
Do you use illegal drugs? □ Yes □ No If Yes, type/ amount/ how long:_____
Have you ever been exposed to, or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis

Review of Systems
Do you currently, or have you ever had any problems in the following areas:

System	Yes	No
Constitutional		
Fever, Weight Gain / Loss	□	□
Integumentary (Skin)	□	□
Neurological		
Headaches	□	□
Migraines	□	□
Seizures	□	□
Eyes		
Loss of Vision	□	□
Blurred Vision	□	□
Distorted Vision / Halos	□	□
Loss of Side Vision	□	□
Double Vision	□	□
Dryness	□	□
Mucous Discharge	□	□
Redness	□	□
Sandy / Gritty Feeling	□	□
Itching	□	□
Burning	□	□
Foreign Body Sensation	□	□
Excess Tearing / Watering	□	□
Glare / Light Sensitivity	□	□
Eye Pain or Soreness	□	□
Chronic Infection of Eye or Lid	□	□
Sites or Chalazion	□	□
Flashes / Floaters in Vision	□	□
Tired Eyes	□	□
Endocrine		
Thyroid / Other Glands	□	□
Psychiatric		
Anxiety	□	□
Depression	□	□
Insomnia	□	□

	Yes	No
Ears / Nose / Mouth / Throat		
Allergies / Hay Fever	□	□
Sinus Congestion	□	□
Runny Nose	□	□
Post – Nasal Drip	□	□
Chronic Cough	□	□
Dry Throat / Mouth	□	□
Respiratory		
Asthma	□	□
Chronic Bronchitis	□	□
Emphysema	□	□
Vascular / Cardiovascular		
Cholesterolema	□	□
Diabetes	□	□
Heart Pain	□	□
High Blood Pressure	□	□
Vascular Disease	□	□
Gastrointestinal		
Diarrhea	□	□
Constipation	□	□
Genitourinary		
Genitals / Kidney / Bladder	□	□
Bones / Joints / Muscles		
Rheumatoid Arthritis	□	□
Muscle Pain	□	□
Joint Pain	□	□
Lymphatic / Hematologic		
Anemia	□	□
Bleeding Problems	□	□
Allergic / Immunologic	□	□

If you answered **YES** to any of the above or have a condition not listed, please explain and list medications:
_____
_____
_____

How did you hear about our Practice?: _____

Signature: _____ Date: _____

Medical / Health Review:
Date:_____ Initial _____ Date:_____ Initial _____ Date:_____ Initial _____
Date:_____ Initial _____ Date:_____ Initial _____ Date:_____ Initial _____