Patient Health History

LAST: ______________________________ FIRST: _______________________________MI: _____ DATE: ________________________
ADDRESS: ________________________________ CITY: ______________________________ STATE:_______ ZIP: _______________
DOB: _______________ AGE: _____ CELL PHONE#: ______________________ HOME PHONE#: ____________________________
EMAIL: _________________________ MARITAL STATUS: ________ LAST EYE EXAM: ______________SSN: ________________
PRIMARY CARE PHYSICIAN: ____PCP PHONE#: _____________________________
MEDICATIONS AND DOSAGES: ____
ALLERGIES: ____
SURGERIES AND DATES: ____

Check if Applicable:

ENDOCRINE:
☐ Diabetes
Type 1: ☐
Type 2: ☐
☐ Thyroid Disease

CONSTITUTIONAL:
☐ Development Disabilities
☐ Cancer

ENT:
☐ Sinusitis
☐ Dry Mouth
☐ Laryngitis

NEUROLOGICAL:
☐ Multiple Sclerosis
☐ Epilepsy
☐ Cerebral Palsy
☐ Tumor
☐ Stroke
☐ Migraine
☐ Autism
☐ Other: ___________________________

PSYCHOLOGICAL:
☐ Depression
☐ Attention Deficit
☐ Anxiety
☐ Bipolar
☐ Other: _________________________

CARDIOVASCULAR:
☐ Hypertension
☐ Heart Disease
☐ Vascular Disease
☐ Congestive Heart Failure

RESPIRATORY:
☐ Asthma
☐ Sleep Apnea
☐ Emphysema
☐ Bronchitis

GASTROINTESTINAL:
☐ Crohn's Disease
☐ Colitis
☐ Ulcer
☐ Acid Reflux
☐ Celiac Disease

GENITOURINARY
☐ Kidney Disease
☐ Prostate Disease/Cancer
☐ STD___________________________
☐ Pregnant
☐ Nursing

MUSCULO/SKELETAL:
☐ Arthritis
☐ Fibromyalgia
☐ Muscular Dystrophy
☐ Osteoporosis
☐ Gout

INTEGUMENTARY:
☐ Eczema
☐ Rosacea
☐ Psoriasis
☐ Herpes Simplex/Cold Sores
☐ Shingles

HEMATOLOGIC/LYMPHATIC:
☐ Anemia
☐ High Cholesterol

OCULAR:
☐ Glaucoma Suspect
☐ Glaucoma Diagnosed
☐ Cataracts w/o surgery
☐ Cataract surgery with implant – Date:__________
☐ Macular Degeneration
☐ Eye surgery:________________________

OCULAR (cont.)
☐ Patching
☐ Inflammatory Disease or Iritis
☐ Strabismus
☐ Amblyopia Lazy Eye
☐ Retinal Detachment
☐ Retinal Degeneration/Disease
☐ Retinal Hole
☐ Keratoconus
☐ Eye Injury

ALLERGY/IMMUNOLOGIC:
☐ Environmental Allergies
☐ Lupus
☐ Sjorgrens Syndrome
☐ Other: ______________________

CURRENT ALCOHOL USE:
☐ Yes ☐ No Amount: ___________

CURRENT TOBACCO USE:
☐ Cigarette ☐ Cigars ☐ Pipe
☐ Smokeless Tobacco

PREVIOUS TOBACCO USE:
☐ Cigarette ☐ Cigars ☐ Pipe
☐ Smokeless Tobacco
Duration _________ Amount ________

DAILY VISION ISSUES:
☐ Eye Strain
☐ Fatigued
☐ Dry Eye
☐ Day/Night Glare
☐ Sandy Gritty Feeling
☐ Itchy/Burning
☐ Distorted Vision/Halos
☐ Flashes/Floaters
☐ Eye Pain or Soreness
☐ Excess Tearing/Watering
☐ Other: ________________________

COMUPTER & CELL PHONE USE
☐ <4 hrs/day ☐ 4-8 hrs/day ☐8 hrs/day

FAMILY OCULAR HEALTH:

Please note if Mother, Father, Siblings or Children have or had any of the following conditions:

☐ Blindness_____________________________________
☐ Cataracts _____________________________________
☐ Crossed Eyes __________________________________
☐ Glaucoma _____________________________________
☐ Macular Degeneration __________________________
☐ Retinal Detachment ____________________________
☐ Other: ____

FAMILY MEDICAL HISTORY:

Please note if Mother, Father, Siblings or Children have or had any of the following conditions:
☐ Arthritis ____
☐ Cancer ____
☐ Diabetes ____
☐ Heart Disease ____
☐ High Blood Pressure ____________________________________
☐ Kidney Disease _______________________________________
☐ Lupus ____
☐ Thyroid Disease ______________________________________