PATIENT HEALTH HISTORY

Patient Name: _____ Date: _____

Primary Care Physician: _____ D.0.B_____

Medical/Family History (use back sheet of paper if more space is needed)

Please list all your current medications/eye drops (include over the counter vitamins and herbal therapy):_____

_____

_____

List all major surgeries (Eye Surgery included):_____

_____

List any allergic reactions to medications or eye drops: _____

_____

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition	Yourself Yes	No		Yes	No
Cataract	□	□	Women- Are you pregnant?	□	□
Eye Turn	□	□	Are you breast feeding?	□	□
Glaucoma	□	□			
Macular Degeneration	□	□			
Retinal Detachment	□	□			

Family Member	Yes	No	Relationship (Blood Relatives Only)
Blindness	□	□	_____
Eye Turn	□	□	_____
Glaucoma	□	□	_____
Macular Degeneration	□	□	_____
Retinal Detachment	□	□	_____

Other: _____

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
- □ Seasonal Allergies
- □ Other (i.e., Latex)

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

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

Skin/Integumentary
- □ None
- □ Eczema
- □ Rosacea
- □ Psoriasis
- □ Other

Psychiatric
- □ None
- □ Depression
- □ Bi-Polar
- □ Schizophrenia
- □ Other

Cardiovascular
- □ None
- □ High Blood Pressure
- □ Heart Disease
- □ Stroke
- □ Vascular Disease
- □ High Blood Cholesterol

Endocrine/Glands
- □None
- □ Diabetes
- □ Hormone Dysfunction
- □ Thyroid Dysfunction
- □ Other

Respiratory
- □ None
- □ Asthma
- □ Bronchitis
- □ Emphysema
- □ Other

Muscle/Skeletal
- □ None
- □ Arthritis
- □ Fibromyalgia
- □ Ankylosing Spondylitis
- □ 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 Former Smoker
- □ Non-Prescription Drugs_____
- □ Alcohol Consumption_____
- □ Weight_____ Height_____

Last Eye Doctor Appointment: _____ Eye Doctor: _____

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____ Reviewed by: Doctor _____

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