PATIENT HEALTH HISTORY

Thank you for choosing our practice. To better serve you, please fill out the information below to the best of your ability.

Date _____ Acct # _____

Patient Name _____ Sex _____ Birth date _____

Soc Sec # _____ Primary Care Physician _____

Address _____

Phone: Home _____ Work _____ Cell _____

Occupation _____ Employer _____ Hours/week _____

EYE HISTORY

Do you currently wear ☐ Glasses ☐ Contact Lenses ☐ Neither

Do you have visual difficulty when reading? ☐ No ☐ Yes

Do you have visual difficulty when driving? ☐ No ☐ Yes

Are you currently using any prescription or non-prescription medication for your eye(s)? ☐ No ☐ Yes

If yes, please list _____

_____

Have you ever had eye surgery? ☐ No ☐ Yes

If yes, please describe:

☐ Right Eye Type of surgery _____ Date _____

Type of surgery _____ Date _____

☐ Left Eye Type of surgery _____ Date _____

Type of surgery _____ Date _____

Have you ever injured your eye? ☐ No ☐ Yes

If yes, please describe _____

_____

Have you ever had any of the following eye conditions?

			Check here if you are currently experiencing this condition				Check here if you are currently experiencing this condition
Glaucoma	☐ No	☐ Yes	☐	Halos	☐ No	☐ Yes	☐
Macular degeneration	☐ No	☐ Yes	☐	Light sensitivity	☐ No	☐ Yes	☐
Cataracts	☐ No	☐ Yes	☐	Redness	☐ No	☐ Yes	☐
Retinal tear or detachment	☐ No	☐ Yes	☐	Itching	☐ No	☐ Yes	☐
Lazy eye/wandering eye	☐ No	☐ Yes	☐	Burning	☐ No	☐ Yes	☐
Eye pain	☐ No	☐ Yes	☐	Dryness	☐ No	☐ Yes	☐
Blurred vision	☐ No	☐ Yes	☐	Sandy/gritty sensation	☐ No	☐ Yes	☐
Decreased vision	☐ No	☐ Yes	☐	Foreign body sensation	☐ No	☐ Yes	☐
Double vision	☐ No	☐ Yes	☐	Discharge	☐ No	☐ Yes	☐
Flashes of light in eye(s)	☐ No	☐ Yes	☐	Crusting on eyelid	☐ No	☐ Yes	☐
Floating dark spots in eye(s)	☐ No	☐ Yes	☐	Drooping eyelid	☐ No	☐ Yes	☐

Other _____

MEDICAL HISTORY

Are you currently being treated for any of the following?

☐ High Blood Pressure ☐ Diabetes ☐ Heart disease ☐ Stroke ☐ Arthritis ☐ Other _____

Have you ever been treated for a serious illness or medical condition? ☐ No ☐ Yes

If yes, please explain _____

_____

Have you had any hospitalization or surgery? ☐ No ☐ Yes

If yes, please explain _____

_____

Please list any medications that you take, prescription or non-prescription:

_____

_____

Do you have:

Drug allergies ☐ No ☐ Yes Please list _____

Food allergies ☐ No ☐ Yes Please list _____

Latex allergies ☐ No ☐ Yes

Patient Name _____ Acct _____

MEDICAL HISTORY (Cont.)

Review of systems:

Are you currently experiencing problems with any of the following?

		If yes, please explain
Sudden weight gain or loss	☐ No ☐ Yes	_____
Chronic fever or chronic fatigue	☐ No ☐ Yes	_____
Heart (example: chest pain, angina, irregular heart beat)	☐ No ☐ Yes	_____
Respiratory (example: coughing, wheezing, shortness of breath, asthma)	☐ No ☐ Yes	_____
Ear/Nose/Throat (example: sore throat, sinus problem, earache, hearing loss)	☐ No ☐ Yes	_____
Gastrointestinal (example: abdominal pain, heartburn, bowel problems, vomiting)	☐ No ☐ Yes	_____
Urinary (example: pain when urinating, blood in urine)	☐ No ☐ Yes	_____
Hematologic/Lymphatic (example: blood disorders, bruising, cuts heal slowly, enlarged glands)	☐ No ☐ Yes	_____
Endocrine (example: thyroid problems)	☐ No ☐ Yes	_____
Integumentary (example: rashes, dry skin)	☐ No ☐ Yes	_____
Musculoskeletal (example: joint pain, stiffness or swelling, muscle pain or weakness)	☐ No ☐ Yes	_____
Neurological (example: numbness, headache, seizures, paralysis)	☐ No ☐ Yes	_____
Psychiatric (example: depression, anxiety, insomnia, confusion)	☐ No ☐ Yes	_____
Allergic/Immunologic (example: reaction to food or drugs, allergies, hay fever)	☐ No ☐ Yes	_____

Social History:

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily How much? _____

Use of tobacco ☐ Never ☐ Previously, but not in past _____ years ☐ Yes _____ packs/day

Family Medical History:

	Age	Medical/Eye Disease	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical status.

_____ _____

Signature of patient (or guardian, if minor) Date

_____ _____

Physician's signature Date