Patient Health History Form

Full Name:	**Date**:
Date of Birth:	**Last Eye Exam/Eye Doctor**:

REASON FOR VISIT: _____

ALLERGIES: ❑ No Allergies to Medications

ALLERGY	ALLERGIC REACTION

MEDICATIONS: ❑ None

** If you need more room to list medications, please write them on a blank sheet of paper with the required information **

MEDICATIONS	DOSE (mg)	TIMES PER DAY

MEDICAL HISTORY: ❑ None

DISEASE/CONDIITON – Please Check ALL that apply to you:	
❑ **Asthma**	❑ **Arthritis (Type:)**
❑ **Cancer (Type: _____ __)**	❑ **Hypothyroidism/Thyroid Disease**
❑ **Depression/Anxiety/Bipolar**	❑ **Stroke**
❑ **Diabetes (Type:)**	❑ **Migraine Headaches**
❑ **Emphysema (COPD)**	❑ **History of MRSA Infection**
❑ **Heart Disease/Heart Attack**	❑ **Other**
❑ **High Blood Pressure/Hypertension**	❑ **Other**
❑ **High Cholesterol**	❑ **Other**

SURGERIES

TYPE (Specify right/left)	DATE	FACILITY/DOCTOR

REVIEW OF SYSTEMS: ☑ Check all that apply

CARDIOVASCULAR	GENITOURINARY	NEUROLOGIC
❑ Chest Pain	❑ Blood in urine	❑ Dizziness
❑ Shortness of Breath	❑ Difficulty urinating	❑ Light-headedness
❑ Palpitations	❑ Pain with urination	❑ Numbness
❑ Leg Swelling	❑ Urgency	❑ Headaches
CONSTITUTIONAL	❑ Frequency	❑ Seizures
❑ Appetite Change	**HEMATOLOGY/ONCOLOGY**	❑ Tremor
❑ Chills	❑ Easy Bruising	**RESPIRATORY**
❑ Fatigue	❑ Easy Bleeding	❑ Wheezing
❑ Fever	**HEAD, EAR, NOSE, THROAT**	❑ Coughing
❑ Unexpected Weight Change	❑ Hearing Loss	❑ Difficulty Breathing
ENDOCRINE	❑ Sore Throat	**OCULAR**
❑ Cold Intolerance	❑ Runny Nose	❑ Loss of vision
❑ Heat Intolerance	❑ Jaw Pain	❑ Blurry vision
❑ Excessive Thirst	❑ Ringing in Ears	❑ Fluctuating Vision
❑ Excessive Urination	**SKIN**	❑ Double Vision
GASTROINTESTINAL	❑ Rash	❑ Redness
❑ Abdominal Pain	❑ Skin Cancer	❑ Discharge
❑ Blood in Stool	❑ Change in moles	❑ Itching
❑ Constipation	**MUSCULOSKELETAL**	❑ Burning
❑ Diarrhea	❑ Back Pain	❑ Glare/Light Sensitivity
❑ Nausea	❑ Joint Pain	❑ Foreign Body Sensation
❑ Vomiting	❑ Muscle Aches	❑ Lazy Eye

VACCINATION HISTORY

Vaccine	Date
Last Influenza Flu Vaccine:	
Last Pneumovax (Pneumonia):	
Last Zoster Vaccine (Shingles):	

SOCIAL HISTORY

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widowed		
Do you smoke? ❑ Yes ❑ No	**Current**: Packs/Day _____ # of years _____	**Past**: Quit Date: _____
Other Tobacco (check one): ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew		
Do you drink alcohol? ❑ Yes ❑ No	❑ Beer ❑ Wine ❑ Liquor	# of Drinks/Week:
Do you use marijuana or recreational drugs? ❑ Yes ❑ No		
Have you ever had a blood transfusion? ❑ Yes ❑ No		
Have you had a fall in the last year that resulted in an injury? ❑ Yes ❑ No		

FAMILY HISTORY ☑ Check all that apply.

*If "apply" please list M=mother; F=father; S=Sibling GM=grandmother; GF=grandfather

❑ **Blindness**	❑ **Arthritis**	❑ **High Blood Pressure**
❑ **Cataract**	❑ **Cancer**	❑ **Kidney Disease**
❑ **Glaucoma**	❑ **Diabetes**	❑ **Lupus**
❑ **Macular Degeneration**	❑ **Heart Disease**	❑ **Stroke**
❑ **Other**	❑ **Other**	❑ **Thyroid Disease**

Patient Signature: _____ Date: _____

Physician Signature: _____Technician'signature_____