HEALTH HISTORY

Patient Information

Patient Name ________________________________ Gender: M / F D.O.B. _______/______/_________

Address ____

City ____________________ County _______________ State __________ Zip Code ______________

Social Security# __________ - ________ - ___________ Home Phone ___________________________

Work Phone __________________________________ Cell Phone _____________________________

Employer ___________________________________ Occupation _____________________________

Emergency Contact Name ______________________ Relation _______________________________

Emergency Contact Phone _____________________ Eye Doctor _____________________________

Family Doctor ________________________________ Family Doctor Phone _____________________

Preferred Pharmacy ___________________________ Phone/Location _________________________

Social History

Does your vision limit any activities of daily living? (please check)

☐ driving ☐ reading ☐ sports ☐ work ☐ other ___________________________________

Do you drink alcohol? No / Yes How often? ____________________________

Do you smoke? No / Yes How much? ____________________ For how many years? __________

Family History

Is there any family history of the following? (please circle) If yes, list family member:

Blindness No / Yes ______________ Cataract No / Yes ________________

Glaucoma No / Yes ______________ Diabetes No / Yes ________________

Macular Degeneration No / Yes ______________

Past Visual & Medical History

Have you ever had any eye injuries or surgeries? ☐ No ☐ Yes If yes, please list them and the approximate year:

____

Have you ever had any other surgeries? ☐ No ☐ Yes If yes, please list them and the approximate year:

____

Do you have any history of cancer? ☐ No ☐ Yes If yes, please explain:

____

please complete other side

NAME____

Please list any medications and why you are taking them:

____ ____

____ ____

____ ____

____ ____

Have you ever taken medications for enlarged prostate (Flomax, Tamsulosin, etc)? ☐ No ☐ Yes

Are you allergic to any latex products? ☐ No ☐ Yes

Are you allergic to any medications? ☐ No ☐ Yes, please list: ______________________________

Do you use oxygen? ☐ No ☐ Yes, only at night ☐ Yes, all the time

Please check any boxes that apply to conditions that you currently have or have had in the past:

Allergic/Immunologic
- ☐ drug allergy
- ☐ environmental allergy
- ☐ other allergy
- ☐ rheumatoid arthritis
- ☐ lupus
- ☐ other _______________
- ☐ **NONE**

Lungs/Breathing
- ☐ cigarette smoker
- ☐ asthma
- ☐ bronchitis
- ☐ emphysema
- ☐ sleep apnea CPAP: Y N
- ☐ other _______________
- ☐ **NONE**

Endocrine
- ☐ non-insulin diabetic
- ☐ insulin diabetic
- ☐ thyroid dysfunction
- ☐ hormonal dysfunction
- ☐ pregnant/breastfeeding
- ☐ other _______________
- ☐ **NONE**

Eyes
- ☐ glaucoma
- ☐ cataracts
- ☐ macular degeneration
- ☐ inflammatory disorders
- ☐ previous surgery
- ☐ other _______________
- ☐ **NONE**

Gastrointestinal
- ☐ Crohn's
- ☐ colitis
- ☐ ulcer
- ☐ digestive problems
- ☐ other _______________
- ☐ **NONE**

Cardiovascular
- ☐ heart disease
- ☐ defibrillator
- ☐ high blood pressure
- ☐ stroke
- ☐ poor circulation
- ☐ high cholesterol
- ☐ other _______________
- ☐ **NONE**

Musculoskeletal
- ☐ arthritis
- ☐ muscular dystrophy
- ☐ fibromyalgia
- ☐ ankylosing spondylitis
- ☐ other _______________
- ☐ **NONE**

Genitourinary
- ☐ STD
- ☐ urinary problems
- ☐ prostate problems
- ☐ other _______________
- ☐ **NONE**

Neurological
- ☐ multiple sclerosis
- ☐ epilepsy
- ☐ other _______________
- ☐ **NONE**

Skin
- ☐ eczema
- ☐ rosacea
- ☐ psoriasis
- ☐ other _______________
- ☐ **NONE**

Constitutional
- ☐ developmental disability
- ☐ sudden weight loss
- ☐ fatigue
- ☐ trauma
- ☐ other _______________
- ☐ **NONE**

Psychiatric
- ☐ depression / anxiety
- ☐ panic disorder
- ☐ schizophrenia
- ☐ dementia/Alzheimer's
- ☐ other _______________
- ☐ **NONE**

Blood/ Lymphatic
- ☐ leukemia
- ☐ anemia
- ☐ large volume blood loss
- ☐ other _______________
- ☐ **NONE**

Ear, Nose, Throat
- ☐ upper respiratory tract infection
- ☐ other _______________
- ☐ **NONE**

For Office Use Only

Medical History Updates: Date: _______________ Tech Initials: _______________ Doctor Initials: _______________

Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:
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