Patient Health History

Name:_____ Birth date ____/____/_____ Date____/____/_____

Address:_____City:_____State:_____Zip:_____

Email Address:_____ Phone Number:_____

Date of last eye exam? __/__/___

Do you wear glasses? YES NO

How old are your glasses?_____

Do you wear contact lenses?
YES NO

If so, what type?

Daily monthly 2-week

Brand _____

Have you had eye surgery? Yes no

For:_____

Reason for today's visit:_____

_____

Are you bothered by any of the following? CIRCLE

Dry / burning eyes: YES NO

Watery eyes: YES NO

Double vision: YES NO

Glare/halos: YES NO

Floaters: YES NO

Flashes of light: YES NO

Itchy eyes: YES NO

Headaches: YES NO

Other discomfort: YES NO

Social History: *This information is strictly confidential.*

Do you drive? YES NO

Do you smoke? YES NO

Current never former

Do you drink alcohol? YES NO

Rarely socially daily heavy

Do you use illegal drugs? YES NO

Personal and Family Medical History

Does anyone in your immediate <u>family</u> have any of the following? CIRCLE

Glaucoma Cataracts Macular Degeneration Diabetes other

Do <u>you</u> have or have you had any of the following eye problems? CIRCLE

Glaucoma Cataracts Macular Degeneration

Eye injury lazy eye other eye disease _____

Please <u>CHECK</u> if you have any of the following health conditions

Constitutional
☐ Fever
☐ Weight loss/gain
☐ Pregnant
☐ Breast feeding
☐ Cancer

Genitourinary
☐ Menopause
☐ Prostate Hyperplasia
☐ Prostate Cancer
☐ STD

Endocrine
☐ Diabetes mellitus
☐ Thyroid dysfunction
☐ Grave's disease

Ears, Nose, Mouth, Throat
☐ Sinus congestion
☐ Runny nose
☐ Post nasal drip
☐ Chronic cough
☐ Dry throat/mouth
☐ Decreased hearing

Bones/joints/muscles
☐ Rheumatoid Arthritis
☐ Osteoarthritis
☐ Muscle/joint pain
☐ Gout

Hematologic
☐ Anemia
☐ Bleeding problems
☐ Leukemia
☐ Clotting problems

Cardiovascular
☐ High blood pressure
☐ High cholesterol
☐ Arrhythmia
☐ Heart disease

Integumentary (skin)
☐ Skin cancer
☐ Rosacea
☐ Eczema
☐ Acne

Allergic/immunologic
☐ Seasonal/Environmental
☐ Lyme disease
☐ Lupus
☐ Sjögren's
☐ Auto-immune condition

Respiratory
☐ Asthma
☐ Chronic bronchitis
☐ Emphysema
☐ COPD

Neurologic
☐ Headaches
☐ Migraines
☐ Seizures
☐ Multiple sclerosis

Other: List
_____
_____
_____
_____
_____
_____

Gastrointestinal
☐ Diarrhea
☐ Constipation
☐ GERD
☐ IBS/IBD

Psychiatric
☐ ADHD/ADD
☐ Depression
☐ Anxiety
☐ Autism
☐ Mood disorder

Please list any medications you are currently taking including over the counter medications:_____

_____

_____

Please list any **medication allergies**/sensitivities:_____

_____

Primary Care Physician:_____Last visit: __/__/___

REVIEWED BY DOCTOR: ___/___/_____