HEALTH HISTORY FORM

Name:_____ Today's Date:_____

Family Physician:_____ Date of Birth:_____

MEDICATIONS

Eye Drops:

Regular Medications:

Drug Allergies:

PAST OCULAR HISTORY (Also list dates and which eye)

Date of last eye exam and where: List all eye problems and injuries:	List all eye surgeries and where performed:

PAST MEDICAL HISTORY

Do you have any of the following medical conditions? (check all that apply): ☐ Lung Disease ☐ Heart Disease ☐ Stroke ☐ Depression ☐ AIDS ☐ Clotting Disorder ☐ Cancer ☐ High Blood Pressure	List any other medical illness or major surgery:

PERSONAL/SOCIAL/FAMILY HISTORY

Smoking Status: ☐ Yes, # of packs/day:_____ # of years:_____ ☐ No
Alcohol: ☐ Yes, # drinks/day:_____ or # drinks/week:_____ ☐ No
Recreational Drug Use: ☐Yes ☐No

Social History: Marital Status:_____ Occupation:_____
***If retired what did you do?_____

Family History: (please check all that apply)
☐ Retinal Detachment ☐ Crossed Eyes ☐ Blood Clotting Problems
☐ Macular Degeneration ☐ Congenital Defects ☐ Cataracts
☐ Glaucoma ☐ Corneal Transplant ☐ Heart Disease
☐ Diabetes

Physician Signature / Date:_____ _____

Health History Form

Please check what pertains to your health today or leave blank if none, in each category:

Constitution:
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weight gain/loss
- ☐ Other:

Head/Ears/Nose/Throat:
- ☐ Hearing loss
- ☐ Sinus congestion
- ☐ Pain
- ☐ Sore throat
- ☐ Ringing in ears
- ☐ Dizziness
- ☐ Other:

Cardiovascular:
- ☐ Chest pain
- ☐ Heart failure
- ☐ Heart murmur
- ☐ High cholesterol
- ☐ Palpitations
- ☐ Other:

Respiratory:
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic cough
- ☐ COPD
- ☐ Shortness of breath
- ☐ Tuberculosis exposure
- ☐ Wheezing
- ☐ Other:

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ GERD
- ☐ Nausea
- ☐ Ulcers
- ☐ Vomiting
- ☐ Other:

Genitourinary:
- ☐ Blood in urine
- ☐ Discharge
- ☐ Impotence
- ☐ Incontinence
- ☐ Infection – Urinary
- ☐ Kidney stones
- ☐ STDs
- ☐ Other:

Musculoskeletal:
- ☐ Arthritis
- ☐ Gout
- ☐ Joint pain
- ☐ Low back pain
- ☐ Muscle aches/cramps
- ☐ Swollen joints
- ☐ Other:

Integumentary:
- ☐ Rosacea
- ☐ Eczema
- ☐ Hives
- ☐ Pigmented lesions
- ☐ Skin cancer/tumors
- ☐ Other:

Neurological:
- ☐ Headache/Migraine
- ☐ Memory loss
- ☐ Numbness
- ☐ Paralysis
- ☐ Seizures
- ☐ Tingling
- ☐ Tremors
- ☐ Stroke
- ☐ Other:

Endocrine (Metabolic):
- ☐ Cold/Heat intolerance
- ☐ Blood Sugar Problems
- ☐ Excessive hunger/thirst
- ☐ Excessive Urination
- ☐ Thyroid problems
- ☐ Other:

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Other:

Hematological (blood):
- ☐ Easy bruising
- ☐ HIV virus
- ☐ Prior Transfusions
- ☐ Other:

Allergic/Immunology:
- ☐ Asthma
- ☐ Hives
- ☐ Seasonal allergies
- ☐ Bee sting allergies
- ☐ Latex allergies
- ☐ Other:

Have you ever taken steroid medication of any kind? If so, why?

Are you taking aspirin or aspirin-related products, Coumadin, or blood thinners?

Any other conditions we should be aware of?

Physician Signature / Date:_____ _____