

Patient Name: _____ **DOB:** _____

Patient Address: _____ **Phone:** _____

Primary Care Physician: _____ **Reason for Visit Today** _____

PATIENT HEALTH HISTORY

Medical/Family History (use back sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins and herbal therapy): _____

List all major surgeries (Eye Surgery included): _____

List allergic conditions: (e.g. medications, seasonal, mold, dust, latex, eye drops): _____

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition	Yourself			Yes	No
	Yes	No			
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Women are you Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Eye Turn	<input type="checkbox"/>	<input type="checkbox"/>	Are you breast feeding?	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>			
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>			
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>			
	Family Member		Relationship (Blood Relatives Only)		
	Yes	No			
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Eye Turn	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Other:	_____				

Review of Systems

Please check below if you have or ever had problems with the following conditions:

<u>Allergic/Immunologic</u> <input type="checkbox"/> None <input type="checkbox"/> Lupus (SLE) <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Environmental Allergies <input type="checkbox"/> Other	<u>Ear, Nose and Throat</u> <input type="checkbox"/> None <input type="checkbox"/> Sinusitis <input type="checkbox"/> Upper Respiratory Tract Infection <input type="checkbox"/> Other	<u>Gastrointestinal</u> <input type="checkbox"/> None <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Colitis <input type="checkbox"/> Acid Reflux/Ulcer <input type="checkbox"/> Other	<u>Skin</u> <input type="checkbox"/> None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other	<u>Psychiatric</u> <input type="checkbox"/> None <input type="checkbox"/> Depression <input type="checkbox"/> Bi-Polar <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other
<u>Cardiovascular</u> <input type="checkbox"/> None <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Vascular Disease	<u>Endocrine/Glands</u> <input type="checkbox"/> None <input type="checkbox"/> Diabetes <input type="checkbox"/> Hormone Dysfunction <input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Other	<u>Respiratory</u> <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Other	<u>Muscle/Skeletal</u> <input type="checkbox"/> None <input type="checkbox"/> Arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Other	<u>Genital/Urinary</u> <input type="checkbox"/> None <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> HIV Positive <input type="checkbox"/> Herpes/Chlamydia <input type="checkbox"/> Other
<u>Hematologic/Lymphatic</u> <input type="checkbox"/> None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Other	<u>Neurological</u> <input type="checkbox"/> None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Tremors <input type="checkbox"/> Other	<u>General Health</u> <input type="checkbox"/> None <input type="checkbox"/> Weight loss/gain <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Trauma	<u>Social</u> <input type="checkbox"/> Tobacco Use: Current Smoker Previous Smoker <input type="checkbox"/> Non-Prescription Drugs _____ <input type="checkbox"/> Alcohol Consumption _____ <input type="checkbox"/> Weight _____ Height _____	

Please sign below to acknowledge that this form will become a part of the patient's medical record.

Signature: _____ Date: _____ Reviewed by Doctor's initials : _____

