PATIENT HEALTH HISTORY

Patient Name: ____ D.O.B.______________________________

Primary Care Physician: ____ Date Last Seen: ______________________________

Medical/ Family History (use back of sheet if necessary)

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

____

____

List all major surgeries (Eye surgery included):____

____

List any **ALLERGIC** reactions to medications or eye drops: ____

____

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

Disease/Condition	**Yourself**	
	Yes	**No**
Cataract	●	●
Eye Turn	●	●
Glaucoma	●	●
Macular Degeneration	●	●
Retinal Detachment	●	●

	Yes	**No**
Women: Are you pregnant? :	●	●
Breastfeeding? :	●	●

	Family Member		**Relationship (**Blood Relatives Only**)**
	Yes	**No**	
Blindness	●	●	________________________________
Eye Turn	●	●	________________________________
Glaucoma	●	●	________________________________
Macular Degeneration	●	●	________________________________
Retinal Detachment	●	●	________________________________

Other: ____

Review of Systems: **Please indicate below if you have had problems with the following conditions**:

Allergic/ Immunologic	**Ear, Nose and Throat**	**Gastrointestinal**	**Skin/ Integumentary**	**Psychiatric**
None	None	None	None	None
Lupus (SLE)	Sinutis	Crohn's Disease	Eczema	Depression
Rheumatoid Arthritis	Upper Respiratory Tract Infection	Colitis	Rosacea	Bi-Polar
Environmental Allergies	Other	Acid Reflux/ Ulcer	Psoriasis	Schizophrenia
Seasonal Allergies		Other	Other	Other
Other (i.e. Latex)				

Cardiovascular	**Endocrine/Glands**	**Respiratory**	**Muscle/ Skeletal**	**Genital/Urinary**
None	None	None	None	None
High Blood Pressure	Diabetes	Asthma	Arthritis	Urinary Tract Infection
Heart Disease	Hormone Dysfunction	Bronchitis	Fibromyalgia	HIV Positive
Stroke	Thyroid Dysfunction	Emphysema	Ankylosing Spondylitis	Herpes/ Chlamydia
Vascular Disease	Other	Other	Other	Other
High Cholesterol				

Hematologic/ Lymphatic	**Neurological**	**General Health**	**Social**
None	None	Weight loss/ gain	Tobacco Use: Never Current Smoker
Anemia	Multiple Sclerosis	Fever	Former Smoker
Leukemia	Epilepsy	Fatigue	Non-Prescription Drugs ____________________
Bleeding Disorder	Tremors	Trauma	________________________________
Cancer	Other		

Please sign below to acknowledge that this form is current:

Signature: ____Date: ____________________ Reviewed by Doctor: ______