Patient Health History Form

Reason for Visit: ____

Please indicate if you have medical conditions involving the following body systems:

1. General Constitution: Y/N
2. Ears/Nose/Throat/Mouth: Y/N
3. Heart Conditions: Y/N
4. High Blood Pressure: Y/N
5. Asthma or Lung Conditions: Y/N
6. Genitourinary: Y/N
7. Muscle/Joint Conditions: Y/N
8. Stomach/Intestinal Conditions: Y/N
9. Skin Conditions: Y/N
10. Stroke/Neurological Disease: Y/N
11. Mental Health Conditions: Y/N
12. Endocrine (e.g. Thyroid): Y/N
13. Diabetes: Y/N
    Date Diagnosed:_______________
14. Blood Disorders: Y/N
15. Allergies/Immunologic: Y/N
16. Cancer Y/N
17. Other
    ____

Please specify conditions that were marked Y (Arthritis, GERD, Anxiety etc.):

____

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Do you have any of the following eye diseases or eye symptoms?

Glaucoma: Y/N
Dry Eyes: Y/N
Cataracts: Y/N
Double Vision: Y/N

Macular Degeneration: Y/N
Retinal Detachment: Y/N
Eye Surgery: Y/N
Other Disease:
____

Itch: Y/N
Lazy Eye: Y/N
Burn: Y/N
Water: Y/N

Are you a current/previous/non-smoker? (circle)

Do you use alcohol? Daily Socially None (circle)

Other substances? ____________________

Do you wear glasses/contact lenses/no correction? (circle)

Medications: Please list all medications you currently take, including any over the counter meds:

____

____

Medication Allergies: Please list all medications that you have allergies to:

____

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IMMEDIATE FAMILY HISTORY

Glaucoma:	Y/N	Relation________	Diabetes:	Y/N	Relation_________
Retinal Detachment:	Y/N	Relation________	High Cholesterol:	Y/N	Relation_________
Cataracts:	Y/N	Relation________	Heart Issues:	Y/N	Relation_________
Crossed/Lazy Eye:	Y/N	Relation________	High Blood Pressure:	Y/N	Relation_________
Macular Degeneration:	Y/N	Relation________	Thyroid Issues:	Y/N	Relation_________
Blindness:	Y/N	Relation________	Cancer:	Y/N	Relation_________