PATIENT HEALTH HISTORY **2 pages**

Name____Date of birth___________Date_________
Primary care physician______________________________Last primary care visit________________
Last eye exam______________________________________Last eyeglasses______________________
What is the main reason for this visit?
____**Pregnant** yes no

VISION AND OCULAR HISTORY

With glasses or contacts

Poor near vision	yes no	Headache reading	yes no	Poor night vision	yes no
Poor far vision	yes no	Neck/eye pain on computer	yes no	Fluctuating vision	yes no
Want contacts	yes no	Fatigue/tired when reading	yes no	Itchy watery eyes	yes no
Want sunglasses	yes no	Upgrade eyewear	yes no	Want LASIK	yes no

Glaucoma	yes no	Loss of vision	yes no
Cataract	yes no	Crossed Eyes	yes no
Macular Degeneration	yes no	Lazy Eyes	yes no
Eye Injury	yes no	Diabetes	yes no
Retinal Disease	yes no	Dry eye	yes no
Eye Surgery	yes no	Refractive	yes no
Other Diseases ______________________		Floaters/Spots/Flashes	yes no

FAMILY HISTORY

Notate relationship

Glaucoma____Amblyopia____________________________
Cataracts____Diabetes______________________________
Macular Degeneration__________________________________Cancer_______________________________
Eye Injury____Heart Disease_________________________
Retinal Disease_______________________________________Hypertension_________________________
Blindness____High Cholesterol_______________________
Strabismus____Kidney_______________________________
Other____Stroke_______________________________

SOCIAL HISTORY

Smoker: Current, Former or Never______________________________Occupation ____________________

Recreational Drugs____Hobbies ______________________

Alcohol Consumption____Computer Use_____________hours

MEDICATIONS

Please list all medications, including over the counter, herbal or supplements

____
____
____

GO TO NEXT PAGE, GO TO NEXT PAGE

ALLERGY TO MEDICATIONS

Please list if any: ____________________

REVIEW OF SYSTEMS

Circle or **list** any current problems

Constitution

Fatigue	yes no
Weight change	yes no
Sleep apnea	yes no

Cardiovascular

High blood pressure	yes no
Stroke	yes no
Heart attack	yes no
Slow heart rate	yes no
Irregular heart rate	yes no
High cholesterol	yes no
Major loss of blood	yes no

Ear, Nose ,Throat

Sinusitis	yes no
Dry mouth	yes no

Respiratory, Lungs

Asthma	yes no
Short of breath	yes no
TB	yes no

Stomach, Intestine

Colitis	yes no
Heartburn	yes no
Hepatitis	yes no
Liver problems	yes no

Urinary, Reproductive

Prostate	yes no
Kidney	yes no
Erectile dysfunction	yes no
Menopause	yes no

Bone, Muscle, Joints

Joint ache	yes no
Osteoarthritis	yes no

Skin, Hair, Nails

rosacea	yes no
acne	yes no
hair loss	yes no
rash	yes no

Neurologic

Memory problems	yes no
Migraine	yes no

Psychiatric

Anxiety	yes no
ADD/ ADHD	yes no
Depression	yes no

Endocrine, Hormonal

Diabetic	yes no
Thyroid dysfunction	yes no
Hormone balance	yes no

Blood, Circulation

Sickle cell	yes no
Blood clotting	yes no
Anemia	yes no

Allergic, Immune

Rheumatoid arthritis	yes no
HIV	yes no
Lupus	yes no
Sjogrens Syndrome	yes no
Auto immune	yes no

Other not listed________________________________

Cancer or Surgeries______________________________

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Signature____Date_____________