PATIENT HEALTH HISTORY

Please review, make necessary changes and supply any missing information.

Patient Name				**Date of Birth**	
Primary Care Physician		**Height**		**Weight**	
Last Eye Doctor				**Approximately when was your last eye exam**	

REVIEW OF SYSTEMS	
Please circle all that apply:	
Constitution	Insomnia, Sudden Weight Loss, Fatigue, Fever, Sudden Weight Gain, Sleep Apnea
Cardiovascular	Angina, Chest Pain, Congestive Heart Failure, Hypertension, Low Blood Pressure, Heart Disease, High Cholesterol, Arrhythmia, Heart Attack, Pacemaker
Ears, Nose, Mouth, Throat	Chronic Colds, Chronic Sinusitis, Ear Infections, Hearing Difficulty, Ringing in Ears
Respiratory	Asthma, COPD, Bronchitis, Tuberculosis, Shortness of Breath, Sarcoid, Apnea
Gastrointestinal	Abdominal Pain, Crones Disease, Colitis, Hepatitis, GERD, Ulcer, Liver Disease
Genitourinary	Kidney Disease, Frequent UTI, Prostate Disease
Musculoskeletal	Arthritis, Bone Cancer, Gout, Joint Pain, Muscle Pain, Osteoporosis
Integumentary	Skin Cancer, Dermatitis, Dryness, Eczema, Rosacea
Neurological	Vertigo, Epilepsy, Migraines, Paralysis, Seizures, Headaches, Stroke, Multiple Sclerosis, Mini Stroke (TIA), Parkinson's Disease
Psychiatric	Depression, Dementia, Anxiety
Endocrine	Type 1 Diabetes, Type 2 Diabetes, Gestational Diabetes, Pre-diabetes, Hypoglycemic, Thyroid Disease
Hematologic/ Lymphatic	Anemia, Blood Disorders, Leukemia, Lyme Disease, Lymphoma, HIV, Lupus
Allergic / Immunologic	Allergy Shots, Immune Disorder, Seasonal Allergies
Other	

Pregnancy Due Date	

DIABETIC INFORMATION		
SMBS	**Date of Test/Value**	
	When?	
HgbA1c	**Date of Test/Value**	
	When?	

OCULAR SURGICAL INFORMATION				
Date	**Eye**	**Procedure**	**Surgeon**	

PATIENT OCULAR HISTORY		FAMILY HISTORY	
Please list any past or present ocular illnesses, symptoms or problems			**Relationship**
Glaucoma		**Glaucoma**	
Cataracts		**Cataracts**	
Age-Related Macular Degeneration		**Age-Related Macular Degeneration**	
Eye Injury		**Retinal Disease**	
Retinal Disease		**Blindness**	
Other Disease		**Strabismus**	
Blindness		**Amblyopia**	
Strabismus		**Diabetes**	
Amblyopia		**Cancer**	
Diabetes		**Heart Disease**	
Dry Eye		**Hypertension**	
Refractive		**High Cholesterol**	
Other		**Kidney Disease**	
		Stroke	

Do you work on a computer?		**Hours per day**	

SOCIAL HISTORY	
Do you use recreational drugs?	Yes No
What type of alcohol do you drink, how much and how often?	
Are you a smoker, former smoker or never smoked? Do you smoke everyday or some days?	
What type of tobacco do you use, how much, how often and for how long?	
Occupation	
Work status / duties	
Hobbies	

ALLERGIES			
Allergy	**Onset Date**	**Reaction**	**Severity**

MEDICATIONS			
Please cross out any medications that you are no longer taking **Please list all prescriptions, over the counter and herbal medications**			
Date	**Name**	**Strength**	**Directions**

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CONTACT LENS HISTORY					
Type of contact lenses you currently use (gas permeable, soft daily, extended)			**How often do you replace your contacts?** (daily, weekly, monthly)		
Average number of hours that you wear your contacts		**Number of hours worn today**		**Wearing Type** (daily, extended)	

Do you wear glasses?

MEDICAL ALERTS
Please list all medical alerts (i.e., Do Not Dilate, epilepsy, DNR / DNI)