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
Cataract	[ ]	[ ]
Eye Turn	[ ]	[ ]
Glaucoma	[ ]	[ ]
Macular Degeneration	[ ]	[ ]
Retinal Detachment	[ ]	[ ]

	Yes	No
Women are you Pregnant?	[ ]	[ ]
Are you breast feeding?	[ ]	[ ]

	Family Member Yes	No	**Relationship** (Blood Relatives Only)
Blindness	[ ]	[ ]	______________________
Eye Turn	[ ]	[ ]	______________________
Glaucoma	[ ]	[ ]	______________________
Macular Degeneration	[ ]	[ ]	______________________
Retinal Detachment	[ ]	[ ]	______________________

Other:____

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

Allergic/Immunologic
[ ] None
[ ] Lupus (SLE)
[ ] Rheumatoid Arthritis
[ ] Environmental Allergies
[ ] Other

Ear, Nose and Throat
[ ] None
[ ] Sinusitis
[ ] Upper Respiratory Tract Infection
[ ] Other

Gastrointestinal
[ ] None
[ ] Crohn's Disease
[ ] Colitis
[ ] Acid Reflux/Ulcer
[ ] Other

Skin
[ ] None
[ ] Eczema
[ ] Rosacea
[ ] Psoriasis
[ ] Other

Psychiatric
[ ] None
[ ] Depression
[ ] Bi-Polar
[ ] Schizophrenia
[ ] Other

Cardiovascular
[ ] None
[ ] High Blood Pressure
[ ] Heart Disease
[ ] Stroke
[ ] Vascular Disease

Endocrine/Glands
[ ] None
[ ] Diabetes
[ ] Hormone Dysfunction
[ ] Thyroid Dysfunction
[ ] Other

Respiratory
[ ] None
[ ] Asthma
[ ] Bronchitis
[ ] Emphysema
[ ] Other

Muscle/Skeletal
[ ] None
[ ] Arthritis
[ ] Fibromyalgia
[ ] Ankylosing Spondylitis
[ ] Other

Genital/Urinary
[ ] None
[ ] Urinary Tract Infection
[ ] HIV Positive
[ ] Herpes/Chlamydia
[ ] Other

Hematologic/Lymphatic
[ ] None
[ ] Anemia
[ ] Leukemia
[ ] Bleeding Disorder
[ ] Other

Neurological
[ ] None
[ ] Multiple Sclerosis
[ ] Epilepsy
[ ] Tremors
[ ] Other

General Health
[ ] None
[ ] Weight loss/gain
[ ] Fever
[ ] Fatigue
[ ] Trauma

Social
[ ] Tobacco Use:
Current Smoker Previous Smoker
[ ] Non-Prescription Drugs_________________
[ ] Alcohol Consumption__________________
[ ] 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 :__________

_______________________________ _____________________ __________

_______________________________ _____________________ __________