

# Health History Form



Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical Doctor:	Phone Number:
Current Eye Doctor:	Phone Number:
Pharmacy of Choice:	Phone Number:

Do you have any special needs?      Wheelchair      Walker      Hearing Aids  
 Interpreter (Language): \_\_\_\_\_      Other: \_\_\_\_\_

Do you wear glasses: Y / N      Do you wear contacts: Y / N      Hard      Soft

**Medications:** Please include name of medication, dosage, and how you are taking the medication (or bring a copy of your medication list)

**1. Over-the-counter Medications:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**2. Prescription Medications:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Surgeries:**

\_\_\_\_\_  
 \_\_\_\_\_

**History of Trauma/ Major Injuries (including eyes):** \_\_\_\_\_

**Family History / Relationship to patient: Mother, Father, Grandparent, Sibling**

<input type="checkbox"/> Cataracts		<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Glaucoma		<input type="checkbox"/> Heart Attacks / Disease	
<input type="checkbox"/> Macular Degeneration		<input type="checkbox"/> Cancer / Type / Location	
<input type="checkbox"/> Retinal Detachment		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Strokes	
<input type="checkbox"/> Strabismus / Muscle Problems		<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Hereditary Eye Disease		<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Other:			

**General Patient Health History:** If you have the following health conditions, please check:

**X Past History      Please Explain**

<input type="checkbox"/> Blurred Vision		<input type="checkbox"/> Dry Eyes / Tearing	
<input type="checkbox"/> Loss of Vision		<input type="checkbox"/> Itching (eyeball or eyelid)	
<input type="checkbox"/> Double Vision		<input type="checkbox"/> Lumps / bumps in eyelids	
<input type="checkbox"/> Strabismus / Muscle		<input type="checkbox"/> Cataracts	
<input type="checkbox"/> Floaters		<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Flashing Lights		<input type="checkbox"/> Macular Degeneration	

## Review of Systems

### Ears, Nose, Mouth, Throat

- Hearing Problems
- Sinus Problems
- Throat or Mouth Problems

### Cardiovascular – Heart

- Atrial Fibrillation
- Abdominal Aortic Aneurysm
- Angina (chest pain / discomfort)
- Arrhythmia – Irregular Heartbeat
- Blood Clots (DVT) *Deep Vein Thrombosis*
- Carotid Artery Disease
- Congestive Heart Failure
- Coronary Artery Disease
- Heart Murmur
- Heart Valve Disease
- High Cholesterol
- Hypertension
- Hypotension
- Myocardial Infarction-Heart Attack
- Rheumatic Fever

### Respiratory – Breathing

- Asthma
- Emphysema
- Bronchitis
- Chronic Cough
- COPD
- Shortness of Breath
- Sleep Apnea
  - CPAP w/Oxygen
  - CPAP without Oxygen
- Tuberculosis

### Gastrointestinal Disease – Stomach

- Acid Reflux – Heartburn
- Colitis – Ulcerative
- Diverticulitis / Diverticulosis
- Gastric Stomach Ulcer
- Hiatal Hernia
- Irritable Bowel Syndrome (IBS)

### Genitourinary

- Bladder Incontinence
- Chronic Dialysis
- Cystitis – (UTI) *Urinary Tract Infection*
- Enlarged Prostate
- Kidney Stones
- Prostate Cancer
- Renal Insufficiency
- Renal Failure
- Uterine Disease

### Integumentary Disease (Skin)

- Eczema
- Psoriasis

### Musculoskeletal (muscles, joints, bones)

- Arthritis
- Arthritis (Rheumatoid)
- Gout
- Osteoporosis
- Osteopenia
- Polymyalgia

### Neurological

- ADHD / ADD
- Alzheimer's
- Dementia
- Anxiety
- Depression
- Speech Delay
- Down Syndrome
- Cerebral Palsy
- Multiple Sclerosis
- Muscular Dystrophy
- Polio
- Neuropathy
- Parkinson's
- Fibromyalgia
- Psychiatric Disorder
- Seizure Disorder
- Mini Strokes (TIA)
- Stroke (CVA)

### Hematologic / Lymphatic (Blood)

- Anemia
- Bleeding Disorder
- Blood Transfusions
- Hepatitis
- Liver Disease
- Malignant Hyperthermia

### Endocrine

- Diabetes Mellitus, Type 1 (insulin)
- Diabetes Mellitus, Type 2 (diet controlled)
- Diabetes Mellitus, Type 2 (oral meds)
- Diabetes Mellitus, Type 2 (insulin)
- Thyroid Disease
  - Hyperthyroidism
  - Hypothyroidism
  - Other \_\_\_\_\_

### Allergic / Immunologic

- AIDS
- Allergies to:
  - Medications

\_\_\_\_\_

Environmental

\_\_\_\_\_

Seasonal

\_\_\_\_\_

Food

\_\_\_\_\_

Latex

Hay Fever

HIV

Lupus Erythematosus

Myasthenia Gravis

### Cancer

- Bladder
- Breast
- Colon
- Hodgkin's
- Non-Hodgkin's
- Prostate
- Skin
  - Basal Cell
  - Squamous Cell
  - Melanoma
- Leukemia
- Lung
- Lymphoma
- Ovarian
- Thyroid
- Uterine
- Other \_\_\_\_\_

### History of Infection Disease

- Chicken Pox
- Herpes Zoster – Shingles
  - Shingles Vaccine
- MRSA
- Meningitis

### Genetic Disorders

- Chromosome Abnormality
- Syndrome or identified genetic disease
- Retinitis pigmentosa
- Color blindness
- Other \_\_\_\_\_

Please list any other health condition you may have that has not been listed: \_\_\_\_\_