Patient Information & Health History Form

Date:_____

Last Name:_____ **First Name**:_____ **MI**:_____

Date of Birth:_____ Sex: M F Social Security Number: _____

Address: _____ City:_____ Zip: _____

Home Phone: _____ Cell phone: _____

Marital Status: S M W D Spouse Name: _____ Spouse DOB: _____

Emergency Contact Name: _____ Relationship:_____

Best number to contact:_____

Medical Doctor:	Current Eye Doctor:
Pharmacy of Choice:	Location / Phone:

Do you wear glasses: Y / N Do you wear contacts: Y / N ***Our clinic does not prescribe hard contact lenses**.

Medications: *Please **SEND A LIST OF YOUR MEDICATIONS** and dosages or list below (including OTC meds & supplements).*

_____

_____

_____

_____

Surgical History:

_____

_____

_____

Family History:	**Mother**	**Father**	**Sibling**	**Child**	**Grandparent**
☐ **Cataracts**	❑	❑	❑	❑	❑
☐ **Glaucoma**	❑	❑	❑	❑	❑
☐ **Macular Degeneration**	❑	❑	❑	❑	❑
☐ **Retinal Detachment**	❑	❑	❑	❑	❑
☐ **Diabetes**	❑	❑	❑	❑	❑
☐ **Strabismus/Muscle Problems**	❑	❑	❑	❑	❑
☐ **Hereditary Eye Disease**	❑	❑	❑	❑	❑
☐ **High Blood Pressure**	❑	❑	❑	❑	❑
☐ **Heart Attacks / Disease**	❑	❑	❑	❑	❑
☐ **Cancer / Type / Location**	❑	❑	❑	❑	❑
☐ **Kidney Disease**	❑	❑	❑	❑	❑
☐ **Strokes**	❑	❑	❑	❑	❑
☐ **Arthritis**	❑	❑	❑	❑	❑
☐ **Thyroid Disease**	❑	❑	❑	❑	❑
☐ **Other:**	❑	❑	❑	❑	❑

SEE BACK OF FORM

Review of Systems: Do you have a past history or are you being treated for:

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
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ 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
- ☐ Kidney Insufficiency
- ☐ Kidney Disease / 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 Erythematous
- ☐ 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:_____

_____