Patient Health History

Date _____ **Age** _____

Patient's Name _____
First Middle Last

Birth Date _____ Social Security # _____

Please answer the following questions about your medical history.

1. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis etc.?
☐ Yes ☐ No If **Yes** please explain/list : _____

_____

2. Have you had any eye disease (e.g. glaucoma, cataract, retinal detachment, "lazy eye")?
☐ Yes ☐ No If **Yes** please explain/list : _____

_____

3. Do you take any Medications? ☐Yes ☐ No
If **Yes** please list: _____
_____ _____
_____ _____

4. Do you have any drug allergies? ☐ Yes ☐ No
If **Yes** please list: _____
_____ _____
_____ _____

5. DO you have any of the following problems?

	Yes	No	If yes please explain:
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear/nose/throat problems (e.g. hearing loss, sinus problems)	☐	☐	_____
Heart problems (e.g. chest pain, irregular heartbeat)	☐	☐	_____
Respiratory problems (e.g. shortness of breath, wheezing, asthma, bronchitis)	☐	☐	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea)	☐	☐	_____
Urinary Problems (e.g. pain or discomfort, bladder infections)	☐	☐	_____
Skin Disease (e.g. rashes, eczema, dermatitis)	☐	☐	_____
Neuralgic problems (e.g. numbness, weakness, paralysis, headache)	☐	☐	_____
Musculoskeletal problems (e.g. muscle aches, arthritis, swollen joints)	☐	☐	_____
Psychiatric problems (e.g. depression, anxiety)	☐	☐	_____

Please Turn

6. Do any medical or eye diseases run in your family (e.g. glaucoma, diabetes,, high blood pressure, cancer, macular degeneration)? ☐ Yes ☐ No If **Yes** please explain/list:

_____

_____

7. DO you : ☐ Smoke? If **Yes,** how much? ☐ Drink alcohol? If **Yes,** how much?

☐ Use Drugs ☐ Drive?

(CHECK ALL THAT APPLY) Occupation: _____

Reviewed by Physician

Signature Date