

Today's Date: _____
MR# _____

Personal Health History

Patient Name: _____ Occupation: _____ DOB: _____ Age: _____

Please explain your present eye health and vision condition (if known):

YES NO **Do you normally wear glasses or contacts?**
If YES, which do you wear most of the time? Glasses Contacts
If YES, how old is the prescription? _____

YES NO **Do you have a history of any eye disease, eye surgery (including laser surgery) or eye injuries?**
If YES, please list types and dates:

YES NO **Are you currently taking medications of any type (including vitamins and supplements)?**
If YES, please list:

YES NO **Are you allergic to any medications?**
If YES, please list medications and type of reaction:

YES NO Not Applicable **Are you now pregnant or breast feeding?**

Medical History: (check box YES or NO. If YES, also note date when first diagnosed.)

- | | | |
|------------------------------------|-----------------------------|--|
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | High Blood Pressure |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Diabetes |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Heart Disease (congestive heart failure, heart rhythm problem, heart attack, murmur), Type: _____ |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Lung Disease (emphysema, asthma), Type: _____ |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Liver Disease, Type: _____ |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Kidney Disease, Type: _____ |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Gastrointestinal Disease (Crohn's, ulcerative colitis, peptic ulcer), Type: _____ |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Cancer, Type: _____ |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Stroke or TIA's |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | High Cholesterol |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Thyroid Disease |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Migraines |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Sleep Apnea |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Seizures |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Blood/Bleeding Disorder (anemia, blood transfusion), Type: _____ |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Arthritis, Type: _____ |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Emotional Illness (anxiety, depression) |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Cerebral Palsy |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | Prematurity |

Please list any other medical problems that you have been diagnosed with: _____

YES NO **Have you ever had any surgery (not on your eyes)?**
If YES, please list types and dates:

YES NO **Do you smoke cigarettes or use tobacco products?**
 NO, NOT ANY LONGER
If YES, how much or how many cigarettes per day? _____

YES NO **Do you drink alcohol?**
 OCCASIONALLY

YES NO **Are you interested in contact lenses?**

YES NO **Are you interested in laser vision correction?**

Is there a family history of the following?

(Check box YES or NO. If YES, also note relationship: father, mother, etc.)

<input type="checkbox"/> YES	<input type="checkbox"/> NO	Cataracts	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Macular Degeneration
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Glaucoma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Crossed or lazy eye
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Retinal Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Migraine Headaches
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	High Blood Pressure
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Other: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Blindness or tumor/cancer of the eye

Review of Systems: Do you have any of the following symptoms now?

If NO, Please check box. If YES, please circle all words that apply.

<input type="checkbox"/> NO	General:	fever, chills, weight loss, night sweat, scalp tenderness
<input type="checkbox"/> NO	Ears, Nose, Throat:	ear pain, facial pain, chronic cough, dry mouth, sneezing
<input type="checkbox"/> NO	Eye:	pain, blurred vision, double vision, redness, burning, itching, discharge, light sensitivity, flashing lights, floaters
<input type="checkbox"/> NO	Heart:	chest pain, rapid heart beat, high blood pressure
<input type="checkbox"/> NO	Respiratory:	shortness of breath, difficulty breathing, discolored sputum, wheezing, congestion
<input type="checkbox"/> NO	Digestive:	constipation, nausea, vomiting, blood in stools, black tarry stools, diarrhea, upset stomach
<input type="checkbox"/> NO	Genital, Kidney:	increased urinary frequency, pain with urination, impotence
<input type="checkbox"/> NO	Muscle:	pain in joints, pain in muscles, stiffness, swelling, cramps
<input type="checkbox"/> NO	Skin:	rash, bruising, pimples, warts, growths, redness, itching, hives, swelling
<input type="checkbox"/> NO	Neuro:	dizziness, weakness, numbness, tingling, trouble speaking, bowel/bladder dysfunction, loss of balance, headache
<input type="checkbox"/> NO	Psychiatric:	Anxiety, depression, insomnia

If you answered yes to any of the above questions and are not currently receiving care for these symptoms, report them to your family physician as soon as possible.

When did you have your last complete physical exam?

Approximate Date: _____ Family Doctor's name: _____

Please sign and date: _____ (first and last name)

Signature _____ Date _____