Health History

Name:_____ Date:_____

Date of Birth:_____ Primary Care Physician:_____

Height_____ Weight_____ Blood Pressure_____

Please list medications below or provide us with a separate list.

List Medications:	Reason	Dosage	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any medications? No ☐ Yes ☐ If yes, please list and state the reaction:

_____

Ocular History:

Have you been diagnosed with any of the following ocular conditions? If yes, please check the box next to the corresponding condition below.

Glaucoma ☐	Iritis ☐	Injury_____ ☐
Cataracts ☐	Crossed Eyes ☐	Lazy Eye/Amblyopia ☐
Macular Degeneration ☐	Corneal Disease ☐	Surgery_____ ☐
Diabetic Retinopathy ☐	Retinal Disease ☐	Carcinoma ☐

Medical History:

Have you been diagnosed with any of the following medical conditions? If yes, please check the box next to the corresponding condition below.

High blood pressure ☐ Diabetes ☐ High Cholesterol ☐ Cancer ☐ Other_____ ☐

Family History:

Has anyone in your family been diagnosed with any of the following conditions? If yes, please check the box next to the corresponding condition below and also note the family member's relation to you in the space provided (**M= Mother F= Father S= Sibling GP= Grandparent**).

Glaucoma ☐_____	Diabetic Retinopathy ☐ _____
Cataracts ☐_____	Corneal Disease ☐ _____
Macular Degeneration ☐_____	Cancer ☐ _____
High blood pressure ☐_____	Heart Problems ☐ _____
Diabetes ☐_____	Stroke ☐ _____
	Other_____ ☐ _____

Please list any surgeries you have had and the approximate corresponding dates:_____

_____

PLEASE CONTINUE ON BACK SIDE

Review of Systems: Please check the box next to any conditions that you currently have.

Allergic/Immunologic

- Drug allergy ☐
- Environmental allergy ☐
- Rheumatoid arthritis ☐
- Lupus ☐
- Other_____ ☐

Cardiovascular

- Heart disease ☐
- High blood pressure ☐
- Stroke ☐
- Vascular disease ☐
- Other_____ ☐

Constitutional

- Developmental Disability ☐
- Weight loss ☐
- Fever ☐
- Fatigue ☐
- Trauma ☐
- Other_____ ☐

Ear, Nose, Mouth & Throat

- Upper Resp. Infection ☐
- Ear ache ☐
- Runny nose ☐
- Sore throat ☐
- Ringing/Tinnitus ☐
- Other_____ ☐

Endocrine

- Type II Diabetes ☐
- Type I Diabetes ☐
- Thyroid dysfunction ☐
- Hormonal dysfunction ☐
- Other_____ ☐

Eyes

- Glaucoma ☐
- Cataracts ☐
- Macular Degeneration ☐
- Surgery ☐
- Inflammatory disorders ☐
- Blurred vision ☐
- Double vision ☐
- Other_____ ☐

Gastrointestinal

- Crohn's ☐
- Colitis ☐
- Ulcer ☐
- Digestive ☐
- Other_____ ☐

Genitourinary

- STD ☐
- Other_____ ☐

Hematologic/Lymphatic

- Anemia ☐
- Large vol. blood loss ☐
- Leukemia ☐
- Other_____ ☐

Integumentary

- Eczema ☐
- Rosacea ☐
- Psoriasis ☐
- Other_____ ☐

Musculoskeletal

- Fibromyalgia ☐
- Muscular dystrophy ☐
- Osteoarthritis ☐
- Ankylosing spondylitis ☐
- Other_____ ☐

Neurological

- Multiple sclerosis ☐
- Epilepsy ☐
- Alzheimer's ☐
- Parkinson's ☐
- Cerebrovascular ☐
- Other_____ ☐

Psychiatric

- Depression ☐
- Panic disorder ☐
- Schizophrenia ☐
- Other_____ ☐

Respiratory

- Asthma ☐
- Bronchitis ☐
- Emphysema ☐
- Other_____ ☐

Social History:

- Smoking status (please check the box next to the status that applies to you):

Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker ☐

- Do you drink alcohol? No ☐ Yes ☐ If yes, how often?_____
- Have you used any recreational drugs in the past 12 months? No ☐ Yes ☐
- Are you pregnant and / or nursing? No ☐ Yes ☐