HEALTH HISTORY

NAME	AGE:	TODAY'S Date	
We would like to welcome you to our pract with your past health history. Since there information will allow us to treat you more	are many interactions among	a whole person, medications and	please help familiarize us medical conditions, this
	EYE HISTORY		
1. What problem with your eyes brought yo	u here today?	_/	
2. When & where was your last eye exam?			
3. Have you ever been told that you have:	Cataracts? Yes / No Macular Degeneration? Yes /	Glaucoma? No	Yes / No
4. List any eye surgery and/or eye laser surg	geries you have h <mark>ad.</mark>		
Surgery	Which Eye?		hen?
5. List eye drops or eye pills you are taking:	-/		
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/	GENERAL MEDICAL HISTORY		
Medication Allergies		Medication	S ₁
Previous Operations			
Hospitalizations			

HEALTH HISTORY - Continued

Social History:		Family History (And whom?):				
Marital Status		Glaucoma				
Live Alone Live With		Retinal Detachment				
Occupation (Past)		Other Eye Prob				
Occupation (Present)		Father:(Living) Yes/No				
Tobacco UsePack/Day		Died From:				
Alcohol UseDrinks/Day		Mother:(Living) Yes/No				
Illicit Drug Use		Died From:				
		Siblings:				
Family Doctor:		Nearest Relative not living w/you				
		Their phone number:				
PAST/PRESENT MEDICAL PROBLEMS: (Please circle all that you have or have ever had)						
High Blood Pressure	Depression	Cancer	Migraines	Other:		
Diabetes	Fluid in lungs/CHF	Parkinsonism	Stomach Ulcer			
Stroke	Heart Attack	Alzheimer's	Prostate Prob.			
Emphysema/COPD	Irreg. Heartbeat/arrhyth./palp.	Liver Prob.	Thyroid Prob.			
Asthma	Anemia	Hepatitis	Kidney Prob.	-		
Lung Problems	Leukemia	Jaundice	Kidney Stones	-		
	REVIEW OF SYSTEMS: (PI	ease circle any current co	ndition)			
General/Constitutional:	General/Constitutional: fever / weight loss / weight gain / unusually tired / decreased appetite					
Ears/Nose/Throat:	hard of hearing / ear pain / dry mouth / cough / difficulty swallowing / sinus prob.					
Cardiovascular:	irregular heart rhythm / slurred speech / paralysis / numbness / swelling of feet					
Respiratory:	congestion / wheezing / shortness of breath					
Gastrointestinal:	stomach upset / heartburn / constipation / diarrhea / jaundice					
Kidney/Bladder:	painful urination / frequent urination					
Muscles/Bones/Joints:	joint pain / stiffness / arthritis					
Skin:	rash / dandruff					
Neurologic:	numbness / headache					
Psychiatric:	anxiety / insomnia / depression					
Endocrine:	bulging eyes / excessive thirst / excessive urination					
Hematologic/Lymph:	ph: bleeding problem / poor immunity / anemic					
Allergic/Immunity:	y: swollen glands / itching / hives / sneezing					
Reproductive:	pregnant / nursing					
COMMENTS ON ABOVE:						
	/			<u> </u>		
Please list names and addresses of all previous Ophthalmologists and/or Optometrists you have seen.						
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Please bring $\underline{\mathsf{ALL}}$ medications that you are currently taking with you to your appointment.