PATIENT HEALTH HISTORY

PLEASE CIRCLE YES OR NO

PERSONAL INFORMATION

Date _____

Name _____ DOB _____

Address _____ Phone # _____

Employer _____ Phone # _____

Safety Glasses required Yes No Social Security # _____

Insurance _____

Member Name _____ DOB _____

SOCIAL HISTORY

Computer Use .... Yes No Hours per day _____

Smoker ..... Yes No

Alcohol Consumption ..... Yes No

Illegal Substance Usage ..... Yes No

If School Age - Current Progress

Above Average Average Below Average

SELF - HEALTH HISTORY / ROS

Name of Regular Physician: _____

❑ **Constitutional Symptoms**

Developmental Disability ..... No Yes
Recent Weight Change ..... No Yes
Fever ..... No Yes
Fatigue ..... No Yes
Shortness of Breath ..... No Yes
Date _____
Comment _____

❑ **Ears / Nose / Mouth / Throat**

Chronic Sinus Problems ..... No Yes
Hearing Loss ..... No Yes
Onset Date _____
Comment _____

❑ **Respiratory**

Asthma/Bronchitis ..... No Yes
Emphysema ..... No Yes
Onset Date _____
Comment _____

❑ **Hematologic / Lymphatic**

Anemia ..... No Yes
Leukemia ..... No Yes
Large Volume Blood Loss ..... No Yes
Onset Date _____
Comment _____

❑ **Cardiovascular**

Heart Problems ..... No Yes
High Blood Pressure ..... No Yes
Stroke ..... No Yes
Onset Date _____
Comment _____

❑ **Gastrointestinal**

Crohn's Disease ..... No Yes
Ulcer ..... No Yes
Onset Date _____
Comment _____

❑ **Genitourinary**

Urinary Tract Infections ..... No Yes
Kidney Problems ..... No Yes
STD's (HIV, Herpes, Chlamydia) ..... No Yes
Onset Date _____
Comment _____

❑ **Endocrine**

Non-insulin Dependent Diabetes ..... No Yes
Insulin Dependent Diabetes ..... No Yes
Thyroid Problems ..... No Yes
Onset Date _____
Comment _____

❑ **Musculoskeletal**

Arthritis ..... No Yes
Fibromyalgia ..... No Yes
Muscular Dystrophy ..... No Yes
Onset Date _____
Comment _____

❑ **Neurological**

Multiple Sclerosis ..... No Yes
Epilepsy ..... No Yes
Onset Date _____
Comment _____

❑ **Psychiatric**

Depression ..... No Yes
Nervousness/Panic Disorder ..... No Yes
Schizophrenia ..... No Yes
Onset Date _____
Comment _____

❑ **Allergic / Immunologic**

HIV/AIDS ..... No Yes
Lupus ..... No Yes
Cancer ..... No Yes
Environmental/Food Allergy ..... No Yes
Onset Date _____
Comment _____

CONTINUED ON OTHER SIDE

FAMILY (blood relatives) HEALTH HISTORY

Cataract	No	Yes	Diabetes	No	Yes	List any other Health Problems that run in your Family _____
Glaucoma	No	Yes	High Blood Pressure	No	Yes	
Macular Degeneration	No	Yes	Heart Problems/Stroke	No	Yes	
Blindness	No	Yes	Thyroid Problems	No	Yes	
Retinal Detachment	No	Yes	Cancer	No	Yes	
Other			Arthritis	No	Yes	

SELF - OCULAR HISTORY

Date of previous eye exam: _____

Cataract	No	Yes	Injury to Eye or Head	No	Yes	Eye Infections	No Yes
Glaucoma	No	Yes	Ocular Foreign Body Removed	No	Yes	Other _____	
Macular Degeneration	No	Yes	Explain _____			Eye Surgery	No Yes
Blindness	No	Yes	Amblyopia (Lazy Eye)	No	Yes	Explain _____	
Retinal Detachment	No	Yes	Strabismus (Eye Turn)	No	Yes		

PATIENT DRUG ALLERGIES OR SENSITIVITIES

_____

_____

_____

_____

MEDICATION TABLE

Medication	For Condition	Dosage	Date Begun	ANNUAL UPDATE /	/	/	/	/	/	/

COMMENTS:

For office use only.

HEALTH HISTORY & MEDICATIONS REVIEWED

Pts. Initials _____ Date _____ ○

Pts. Initials _____ Date _____ ○

Pts. Initials _____ Date _____ ○

Pts. Initials _____ Date _____ ○

Pts. Initials _____ Date _____ ○

Pts. Initials _____ Date _____ ○

Pts. Initials _____ Date _____ ○

Pts. Initials _____ Date _____ ○