



Health History Form

Patient Information					
Name		Primary Care Physician			
Date of Birth / Age		Pharmacy			
Occupation		Medication or Latex Allergies (list all):			
Interests / Hobbies					
Visit Date					

Eye History:	Right	Left	Medications (list all):	Eye Medications (list all):
Cataract				
Glaucoma				
Lazy eye/Amblyopia				
Iritis				
Cataract surgery				
Other eye surgery				
Eye injury				
Macular Degeneration				
Retinal problems				
Refractive surgery				

		Major Surgery (last 10 years):	

MEDICAL HISTORY				MEDICAL HISTORY (CONT'D)			
Social	Yes	No	1 st use?	Endocrine	Yes	No	When?
Tobacco use?				Diabetes: Circle – Type 1 / Type 2			
Alcohol use?				Thyroid Disease			
Drug use (recreational)?				Kidney Problems			
Do you drive?				Kidney Stones			

Do you have or have you ever had:				Neurological			
Cardiovascular	Yes	No	When?		Yes	No	When?
Heart Attack				Parkinson's			
Chest Pain				Stroke/TIA			
Angina				Multiple Sclerosis			
Congestive Heart Failure				Chronic Headache			
Irregular Heart Beat				Dementia / Alzheimer's			
High Blood Pressure				Hard of Hearing / Deaf			
Low Blood Pressure							
Pacemaker							
Defibrillator							
High Cholesterol							

Respiratory				Musculoskeletal			
	Yes	No	When?		Yes	No	When?
Asthma				Osteo / Rheumatoid Arthritis			
Emphysema				Joint Pain			
COPD							
Bronchitis							
TB: Positive Test? Treated?							

Genitourinary				Gastrointestinal			
	Yes	No	When?		Yes	No	When?
Incontinence				Crohn's / Ulcerative Colitis			
Prostate Treatment (ever used):				Hepatitis A / B / C or Jaundice			
Proscar, Flomax, Tamsulosin							

ENT				Allergic/Immunologic			
	Yes	No	When?		Yes	No	When?
Sinus Congestion				HIV			
				Persistent Infections			

Cancer				Hem/Lymph			
	Yes	No	When?		Yes	No	When?
Type?				Anemia / Bleeding / Bruising			
Treatment: Chemo / Radiation							

Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
M.D.: _____	M.D.: _____	M.D.: _____	M.D.: _____	M.D.: _____	M.D.: _____	M.D.: _____
Tech: _____	Tech: _____	Tech: _____	Tech: _____	Tech: _____	Tech: _____	Tech: _____