PATIENT HEALTH HISTIORY

Patient Name: ______________________________ **DOB**____/____/______ **Gender:** M F **Race:** American Indian or Alaska Native/Asian/Black or African American/Hispanic/Native Hawaiian or Other Pacific Islander/White **Preferred Language**: English Spanish **Preferred Method of Communication**: Email Postal Telephone **Ethnicity**: Hispanic or Latino/Native Hawaiian or Other Pacific Islander/Not Hispanic or Latino

E-mail address:______________________________ **SSN**______________________________

Address: ______________________________ **Insurance:** ______________________________

Phone: Res:__________________ **Wk:**__________________ **Cell**__________________

Primary Care Physician: __________________ **Date Last Seen:** __________ **Occupation:** __________________

Current Pharmacy: __________________ **Employer**______________________________

Person responsible for payment if not yourself:
Legal Name: Last __________________ **First**__________________ **MI**_____
Adress:______________________________
Telephone: Home:__________________ **work**__________________ **Cell**__________________
Relationship to patient:__________________ **Employer**__________________
May we release your medical information: yes no If yes who:
Name__________________ **Relationship**__________________ **Phone**__________________

Medical/Family History (use back sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins and herbal therapy):______________________________

List all major surgeries (Eye Surgery included):______________________________

List any allergic reactions to **medications or eye drops**: ______________________________
Women- Are you pregnant or breastfeeding. Yes No.

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition	Yourself Yes	Yourself No	Family Member Yes	Family Member No	Relationship (Blood Relatives Only)
Cataract	·	·	·	·	______________
Eye Turn	·	·	·	·	______________
Glaucoma	·	·	·	·	______________
Macular Degeneration	·	·	·	·	______________
Retinal Detachment	·	·	·	·	______________
Hypertension	·	·	·	·	______________
Diabetes	·	·	·	·	______________
Blindness	·	·	·	·	______________
Eye Injury	·	·	·	·	______________

Review of Systems Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic
- None
- Lupus (SLE)
- Rheumatoid Arthritis
- Environmental Allergies
- Seasonal Allergies
- Other (i.e., Latex)

Ear, Nose and Throat
- None
- Sinusitis
- Upper Respiratory Tract Infection
- Other

Gastrointestinal
- None
- Crohn's Disease
- Colitis
- Acid Reflux/Ulcer
- Other

Skin/Integumentary
- None
- Eczema
- Rosacea
- Psoriasis
- Other

Psychiatric
- None
- Depression
- Bi-Polar
- Schizophrenia
- Other

Cardiovascular
- None
- High Blood Pressure
- Heart Disease
- Stroke
- Vascular Disease
- High Blood Cholesterol

Endocrine/Glands
- None
- Diabetes
- Hormone Dysfunction
- Thyroid Dysfunction
- Other

Respiratory
- None
- Asthma
- Bronchitis
- Emphysema
- Other

Muscle/Skeletal
- None
- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis
- Other

Genital/Urinary
- None
- Urinary Tract Infection
- HIV Positive
- Herpes/Chlamydia
- Other

Hematologic/Lymphatic
- None
- Anemia
- Leukemia
- Bleeding Disorder
- Other

Neurological
- None
- Multiple Sclerosis
- Epilepsy
- Tremors
- Other

General Health
- None
- Weight loss/gain
- Fever
- Fatigue
- Trauma

Social
- Tobacco Use: Current Smoker Former Smoker
- Non-Prescription Drugs__________________
- Alcohol Consumption__________________
- Weight______________ Height__________

Please sign below to acknowledge that this form is current:

Signature: ______________________________ Date: __________________ Reviewed by Doctor's initials: ______________