

# HEALTH HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_

Medical Doctor's Name: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_

If new to our office, approximate date of last exam: \_\_\_\_\_

Do you wear glasses:  All the time  Occasionally  I do not wear glasses

If occasionally, do you wear them for:  Distance  Reading  Computer Work  Other? \_\_\_\_\_

Do you wear contact lenses:  Yes  No If no,  I have interest in contact lenses  I am not interested

Have you or any family member (parents, grandparents, siblings or children) ever had any of the following:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Eye Surgery            | <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Eye infection or disease | <input type="checkbox"/> Loss of vision |
| <input type="checkbox"/> Eye injury             | <input type="checkbox"/> Floaters or spots    | <input type="checkbox"/> Double vision            | <input type="checkbox"/> Blindness      |
| <input type="checkbox"/> Severe eye pain        | <input type="checkbox"/> Lazy eye/Crossed Eye | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Cataract       |
| <input type="checkbox"/> Eyes burn, itch, water | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Poor Vision              | <input type="checkbox"/> Other _____    |

Please explain: \_\_\_\_\_

Do you work at a computer:  Yes  No Do you play golf:  Yes  No

Please list any hobbies or sports you participate in: \_\_\_\_\_

Please list any medications/drugs you are now taking as well as the reason you take it. Please include both prescription and non-prescription medications.

Drug	Reason Taking	Drug	Reason Taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies to Medications  No  Yes If yes, please list: \_\_\_\_\_

Use of Alcohol, on average:  0-4 drinks per week  5-10 drinks per week  Other \_\_\_\_\_ drinks per week

Use of Tobacco:  0-10 packs in lifetime  More than 10 packs, but none since \_\_\_\_\_  \_\_\_\_\_ packs per day

Have you used an illegal drug in the last 30 days:  No  Yes

Have you ever been exposed to or infected with:  Hepatitis  HIV

**Review of Systems:** Do you or a family member currently have, or have ever had any of the following:

	No	Yes	Yes		No	Yes	Yes
		Self	Family			Self	Family
<b>Constitutional</b>				<b>Vascular/Cardiovascular</b>			
Unusual Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological</b>				High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ear, Nose, Mouth, Throat</b>				<b>Respiratory</b>			
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Gastrointestinal</b>				<b>Bones, Joints, Muscles</b>			
<b>Psychiatric</b>				Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Immune Disorders</b>				Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Skin Disorders</b>				<b>Lymphatic/Hematological</b>			
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Endocrine</b>				<b>Genitourinary</b>			
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have a condition not listed above, please list and explain: \_\_\_\_\_

Reviewed by Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

Medical History Updates for Subsequent Visits; I have read my medical history and confirm its accuracy.

Date	Changes	Patient Signature	Staff Initials	Doctor Initials
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____