Personal Health History

Today's Date:___________________

Patient Name: ____ **Age:**___________________
Last First MI

Address:____ **Phone #: (_____)**________________

Present Medical History

Please answer the following questions regarding you present eye health and vision conditions:

☐ Yes ☐ No **Do you normally wear glasses or contact?**
If yes, which do your wear most of the time? ☐ Glasses ☐ Contacts

☐ Yes ☐ No **Do you have a history of any eye disease, eye surgery (including laser surgery) or eye injuries?**
If yes, please list types and dates: ____
____

☐ Yes ☐ No **Are you allergic to any medications?**
If yes, please explain:____
____

Medical History

Have you ever had any of the following? Please check those that apply:

- ☐ Allergies _____________ _____________________ _____________________
- ☐ Anemia
- ☐ Arthritis ______________
- ☐ Asthma
- ☐ Blood Disease _________
- ☐ Cancer ______________
- ☐ Cerebral Palsy
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Gastrointestinal Disease ____________________
- ☐ Glaucoma
- ☐ Growths ______________
- ☐ Heart Disease _________
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease _____________
- ☐ Liver Disease _______________
- ☐ Lung Disease _______________
- ☐ Mental Disorders ____________
- ☐ Migraines
- ☐ Currently Pregnant/Breast Feeding
- ☐ Premature at Birth
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stroke or TIA's
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ OTHER: __________________ __________________ __________________ __________________

☐ Yes ☐ No **Have you ever had any surgery (not on your eye's)?**
If yes, types and dates:____
____
____

☐ Yes ☐ No **Do you smoke cigarettes or use tobacco products?**
☐ Not Any Longer If yes, how much/many per day:____

☐ Yes ☐ No **Do you drink alcohol?**
☐ Occasionally

Family Medical History

Is there a family history of the following? Please check those that apply and relationship: father, mother, ect.

- ☐ Blindness ____________________
- ☐ Cataracts ____________________
- ☐ Crossed or lazy eye ____________
- ☐ Diabetes _____________________
- ☐ Glaucoma ____________________
- ☐ High Blood Pressure____________
- ☐ Macular Degeneration __________
- ☐ Migraines ____________________
- ☐ Retinal Disease ________________
- ☐ Tumor/Cancer of Eye ___________
- ☐ **OTHER**: ______________________________

Review of Systems

Please check those that apply:

Cardiovascular
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Rapid Heart beat

Digestive
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Blood in Stool
- ☐ Black Tarry Stool
- ☐ Diahrrhea
- ☐ Upset Stomach

Ears, Nose, Throat
- ☐ Ear Pain
- ☐ Facial Pain
- ☐ Chronic Cough
- ☐ Dry Mouth
- ☐ Sneezing

Eyes
- ☐ Pain
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Discharge
- ☐ Light Sensitivity
- ☐ Flashing Lights
- ☐ Floaters

General
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Night Sweats
- ☐ Scalp Tenderness

Kidney, Genital
- ☐ Increased Urinary Frequency
- ☐ Pain with Urination
- ☐ Impotence
- ☐ Bladder/Bowl Dysfunction

Musculoskeletal
- ☐ Pain in Joints
- ☐ Pain in Muscles
- ☐ Stiffnes
- ☐ Swelling

Neurological
- ☐ Dizziness/Loss of Balance
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Trouble Speaking
- ☐ Headaches

Respiratory
- ☐ Shortness of Breath
- ☐ Difficulty Breathing
- ☐ Discolored Sputum
- ☐ Wheezing
- ☐ Congestion

Skin
- ☐ Rash
- ☐ Bruising
- ☐ Warts
- ☐ Growths
- ☐ Redness
- ☐ Hives
- ☐ Swelling

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

If you checked any of the above questions and are not currently receiving care for these symptoms, report them to your Primary Care Physician as soon as possible.

When did you have your last complete physical exam?

______________________________ Approximate Date

______________________________ Primary Care Physician (first and last name)

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor and/or staff at the next appointment without fail.

X ______________________________ Signature of patient, parent or guardian

______________ Date