HEALTH HISTORY

PATIENT INFORMATION

Last Name:	First Name:	Birth Date:	
Address:	City:	State:	Zip Code:
Social Security #:	Home Phone:	Cell Phone:	
Employer:	Work Phone:	Occupation:	
Email Address:			
Emergency Contact Name:	Relationship:	Phone:	

CARE PROVIDERS

Eye Doctor Name:	Phone:	
Family Doctor Name:	Phone:	
Preferred Pharmacy:	Phone:	Location:
Cardiologist Name:	Phone:	
Endocrinologist Name:	Phone:	
Other Name/Specialty:	Phone:	

SOCIAL HISTORY

Does your vision limit any activities of daily living? (please check)

☐ driving ☐ reading ☐ sports ☐ work ☐ other

Do you drink alcohol?	☐ No	☐ Yes	How often?	
Do you smoke?	☐ No	☐ Yes	How much?	For how long?

Medical Office Only *Cessation of Smoking given to patient?* ☐

FAMILY HISTORY

Is there any family history of the following? (please check) If yes, list family member:

☐ Blindness _____ ☐ Cataract _____

☐ Glaucoma _____ ☐ Diabetes _____

☐ Macular Degeneration

PAST VISUAL & MEDICAL HISTORY

Have you ever had any eye injuries or eye surgeries? Please list them and approximate year:

Have you ever had any other surgeries? Please list them and approximate year:

Do you have a history of cancer? Please explain:

PATIENT NAME:

Please list any medications and why you are taking them:

_____ _____

_____ _____

_____ _____

_____ _____

Are you, or have you ever, taken the following medications:

Flomax(tamsulosin)	☐ No	☐ Yes	Minipress(prazosin)	☐ No	☐ Yes
Hytrin(terazosin)	☐ No	☐ Yes	Ozempic(semaglutide)	☐ No	☐ Yes
Trulictiy(dulaglutide)	☐ No	☐ Yes	Mounjaro(tirzepatide)	☐ No	☐ Yes

Are you allergic to any latex products? ☐ No ☐ Yes

Are you allergic to any medications? ☐ No ☐ Yes, please list:_____

Do you use oxygen? ☐ No ☐ Yes, only at night ☐ Yes, all the time

Please check any boxes that apply to conditions that you currently have or have had in the past:

Allergic/Immunologic
- ☐ drug allergy
- ☐ environmental allergy
- ☐ other allergy
- ☐ rheumatoid arthritis
- ☐ lupus
- ☐ other
- ☐ NONE

Eyes
- ☐ glaucoma
- ☐ cataracts
- ☐ macular degeneration
- ☐ inflammatory disorders
- ☐ previous surgery
- ☐ other
- ☐ NONE

Musculoskeletal
- ☐ arthritis
- ☐ muscular dystrophy
- ☐ fibromyalgia
- ☐ ankylosing spondylitis
- ☐ other
- ☐ NONE

Constitutional
- ☐ developmental disability
- ☐ sudden weight loss
- ☐ fatigue
- ☐ trauma
- ☐ other
- ☐ NONE

Lungs/Breathing
- ☐ cigarette smoker
- ☐ asthma
- ☐ bronchitis
- ☐ COPD
- ☐ emphysema
- ☐ sleep apnea CPAP: Y N
- ☐ other
- ☐ NONE

Gatrointestinal
- ☐ Crohn's
- ☐ colitis
- ☐ ulcer
- ☐ digestive problems
- ☐ other
- ☐ NONE

Genitourinary
- ☐ STD
- ☐ urinary problems
- ☐ prostate problems
- ☐ other
- ☐ NONE

Psychiatric
- ☐ depression/anxiety
- ☐ panic disorder
- ☐ schizophrenia
- ☐ dementia/Alzheimer's
- ☐ other
- ☐ NONE

Endocrine
- ☐ non-insulin diabetic
- ☐ insulin diabetic
- ☐ thyroid dysfunction
- ☐ hormonal dysfunction
- ☐ pregnant/breastfeeding
- ☐ other
- ☐ NONE

Cardiovascular
- ☐ heart disease
- ☐ defibrillator
- ☐ high blood pressure
- ☐ stroke
- ☐ poor circulation
- ☐ high cholesterol
- ☐ other
- ☐ NONE

Neurological
- ☐ multiple sclerosis
- ☐ epilepsy
- ☐ other
- ☐ NONE

Skin
- ☐ eczema
- ☐ rosacea
- ☐ psoriasis
- ☐ other
- ☐ NONE

Blood/Lymphatic
- ☐ leukemia
- ☐ anemia
- ☐ large volume blood loss
- ☐ other
- ☐ NONE

Ear, Nose, Throat
- ☐ Upper respiratory infection
- ☐ other
- ☐ NONE

CURRENT: **HEIGHT:** **WEIGHT:** **BMI:**

For Office Use Only

Medical History Updates:	Date:	Tech Initials:	Doctor Initials:
Date:	Changes made? Yes No	Tech Initials:	Doctor Initials:
Date:	Changes made? Yes No	Tech Initials:	Doctor Initials:
Date:	Changes made? Yes No	Tech Initials:	Doctor Initials: