PATIENT HEALTH HISTORY

Patient Name:_____ DOB ____/_____/_____ Gender: M☐ F ☐

Race: American Indian or Alaska Native/Asian/African American/Hispanic/Hawaiian Or Pacific Islander/White
Ethnicity: Hispanic or Latino/ Hawaiian or Pacific Islander/ **Neither**

Medical/ Family History (use back of 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 **allergies** (including eye drops): _____

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

Disease/Condition	**Yourself**		**Family Member**			
	Yes	No		Yes	No	Relationship (blood Rel)
Cataract	☐	☐	Blindness	☐	☐	_____
Eye Turn	☐	☐	Eye Turn	☐	☐	_____
Glaucoma	☐	☐	Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	Retinal Detachment	☐	☐	_____

Other:_____

Please indicate below if you have or ever had problems with the following condition:

Allergic/ Immunologic	**Ear, Nose and Throat**	**Gastrointestinal**	**Skin/Integumentary**	**Psychiatric**
☐None	☐None	☐None	☐None	☐None
☐Lupus (SLE)	☐Sinusitis	☐Chrohn's Disease	☐Eczema	☐Depression
☐Rheumatoid Arthritis	☐Upper Respiratory	☐Colitis	☐Rosacea	☐Bi-Polar
☐Environment Allergies	Tract Infection	☐Acid Reflux/Ulcer	☐Psoriasis	☐Schizophrenia
☐Seasonal Allergies	☐Other	☐Other	☐other	☐Other
☐Other (i.e.,Latex)				
Cardiovascular	**Endocrine/Glands**	**Respiratory**	**Muscle/Skeletal**	**Genital/Urinary**
☐None	☐None	☐None	☐None	☐None
☐High Blood Pressure	☐Diabetes	☐Asthma	☐Arthritis	☐UTI
☐Heart Disease	☐Hormone Dysfunction	☐Bronchitis	☐Fibromyalgia	☐HIV Positive
☐Stroke	☐Thyroid Dysfunction	☐Emphysema	☐Ankylosing Spondylitis	☐Herpes/Chlamydia
☐Vascular Disease	☐Other	☐Other	☐Other	☐Other
☐High Cholesterol				
Hematologic/Lymphatic	**Neurological**	**General Health**	**Social**	
☐None	☐None	☐None	☐ Tobacco Use:	
☐Anemia	☐Multiple Sclerosis	☐Weight Loss/Gain	☐Current ☐Former	
☐Leukemia	☐Epilepsy	☐Fever	☐Non Rx Drugs:_____	
☐Bleeding Disorder	☐Tremors	☐Fatigue	☐Alcohol Consumption:_____	
☐Other	☐Other	☐Trauma	Weight:_____ Height: _____	

Signature of Patient: _____Date:_____