

HEALTH HISTORY

Fill out this information to the best of your ability. Providing incorrect information can be dangerous to your health. Please inform our office when there are any changes in the medical information you provide below.

Do you currently wear glasses or contacts? All the time Occasionally No
 Do you wear them for Reading TV Computer Work Driving

Have you ever had the following eye conditions? (Circle No or Yes, leave blank if uncertain)

Sandy or Gritty	No	Yes	Glaucoma, Cataracts, Etc.	No	Yes	Loss of Side Vision	No	Yes
Itching	No	Yes	Loss of Vision	No	Yes	Double Vision	No	Yes
Burning	No	Yes	Blurred Vision	No	Yes	Dryness	No	Yes
Foreign Body Sensation	No	Yes	Fluctuating Vision	No	Yes	Mucous Discharge	No	Yes
Excess Tearing	No	Yes	Distorted Vision	No	Yes	Redness	No	Yes
Glare/Light Sensitivity	No	Yes	Tired Eyes	No	Yes	Lazy Eye/Crossed Eye	No	Yes
Pain or Soreness	No	Yes	Drooping Eyelid	No	Yes	Other	No	Yes
Infection	No	Yes						

Review of Systems: Please indicate any personal history below:

<input type="checkbox"/> Constitutional Symptoms Good general health lately No Yes Recent weight change No Yes Fever No Yes Fatigue No Yes <input type="checkbox"/> Ear/Nose/Mouth/Throat Earaches or drainage No Yes Chronic sinus problem or rhinitis No Yes Nose bleeds No Yes Mouth sores No Yes Bleeding gums No Yes Bad breath or bad taste No Yes Hearing loss or injury No Yes Sore throat or voice change No Yes <input type="checkbox"/> Neurological Numbness or tingling sensation .. No Yes Paralysis No Yes Headaches No Yes Light headed or dizzy No Yes Convulsions or seizures No Yes Tremors No Yes Head Injury No Yes <input type="checkbox"/> Hematologic/Lymphatic Anemia No Yes Bleeding or bruising tendency ... No Yes Slow to heal after cut No Yes Phlebitis No Yes Past transfusion No Yes Enlarged glands No Yes	<input type="checkbox"/> Respiratory Chronic or frequent coughs No Yes Shortness of breath No Yes Wheezing No Yes Spitting up blood No Yes <input type="checkbox"/> Gastrointestinal Loss of appetite No Yes Change in bowel movements ... No Yes Frequent diarrhea No Yes Nausea or vomiting No Yes Painful bowel movements or constipation No Yes Rectal bleeding or blood in stool No Yes Abdominal pain No Yes <input type="checkbox"/> Psychiatric Memory loss or confusion No Yes Depression No Yes Nervousness No Yes Insomnia No Yes <input type="checkbox"/> Cardiovascular Heart trouble No Yes Chest pain or angina pectoris ... No Yes Palpitation No Yes Shortness of breath w/walking or lying down No Yes Swelling of feet, ankles or hands No Yes	<input type="checkbox"/> Musculoskeletal Joint pain No Yes Joint stiffness or swelling No Yes Muscle pain or cramps No Yes Weakness pain or cramps No Yes Back pain No Yes Cold extremities No Yes Difficulty in walking No Yes <input type="checkbox"/> Allergic/Immunologic History of skin reaction or other adverse reaction to: Penicillin or other antibiotics No Yes Morphine, Demerol, or other narcotics No Yes Novocain or other anesthetics ... No Yes Aspirin or other pain remedies .. No Yes Tetanus antitoxin or other serums No Yes Iodine, Merthiolate or other antiseptics No Yes Other drugs/medications: _____ _____ _____ Known food allergies: _____ _____ _____
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Use of Alcohol: Never Rarely Moderate Daily
 Use of Tobacco: Never Previously but not in the past _____ year(s) _____ Current packs/day: _____

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

Medications: (include Non-Prescription) _____

Family Medical History:	Age	Medical/Eye Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____