NEW PATIENT HEALTH HISTORY

NAME:_____ **AGE:**_____ **DATE:**_____ **PHONE:**_____

We would like to welcome you to our practice. To enable us to treat you as a whole person, please help familiarize us with your past health history. Since there are many interactions among medications and medical conditions, this information will allow us to treat you more safely. Remember, all information is confidential and will only be released upon your written authorization. Thank you for your understanding.

EYE HISTORY

1. What problem with your eyes brought you here today? _____
2. Are you interested in: ❑ laser surgery ❑ eyeglasses ❑ sunglasses ❑ contact lenses
3. When and where was your last eye exam? _____
4. Have you ever been told that you have **CATARACTS?** Yes/No
   GLAUCOMA? Yes/No **MACULAR DEGENERATION?** Yes/No
5. List any eye surgery and/or eye laser surgeries that you have had.

Surgery	Which Eye	When

6. List any eye drops or pills taken for your eyes:

GENERAL MEDICAL HISTORY

Medication Allergies

_____
_____
_____

Previous Operations

_____
_____
_____

Medications (other than eye meds)

_____
_____
_____
_____
_____
_____
_____

Hospitalizations:_____

_____ Local Physician _____

Social History

Marital Status: Single Married Divorced Legal Separation Widow/Widower
Live alone? Yes No, live with: Parents Children Spouse Other:_____
Occupation: (Past)_____
Occupation: (Present)_____
Tobacco Use? No Yes, _____Packs per day
Alcohol Use? No Yes, _____Drinks per day
Illicit Drug Use:_____

Please list the names (and if you know the address) of your previous eye care professionals:

_____
_____
_____

Family History (and whom?)
Glaucoma_____
Other Eye Problems_____
Cancer_____
Diabetes_____
Heart Problems_____
Father: (Living) yes/no
Died From:_____
Mother: (Living) yes/no
Died From:_____
Siblings _____

PAST AND PRESENT MEDICAL PROBLEMS

Please circle any of the following you have or have ever had.

Swelling/lymph nodes
Diabetes
Anemia
Arthritis
Cancer
Stroke
Slurred Speech
Facial Palsy
Weakness
Parkinsonism
Depression
Alzheimer's
High Blood Pressure
Swelling of the Feet
Heart Trouble
Irregular Heart Beat
Decreased Appetite

Heart Attack
Chest Pain
Liver Problems
Hepatitis
Jaundice
Headaches
Migraines
Sinus Problems
Lung Problems
Shortness of Breath
Fluid in Lungs
Asthma
Emphysema
Bronchitis
Stomach Problems
Stomach Ulcers
Palpitations

Prostate Problems
Thyroid Problem
Bulging eyes
Weight Loss
Diarrhea
Constipation
Hard of Hearing
Kidney Problems
Kidney Stones
Dandruff
Skin Rashes
Rash on Face
Scaling on Face
Bleeding Problems
Urination Problem
Breast Lump/Pain
Difficulty with Swallowing

If you have any other problems, questions, or concerns that you would like to bring to the doctor's attention, please use the remaining space: