Health History

Name:______________________________
Date:_______________________________
Birthdate:____________ Chart #_________

I. Review of Systems

Eyes

Loss of Vision	Y	N	Blurred Vision	Y	N
Distorted Vision (halos)	Y	N	Loss of Side Vision	Y	N
Double Vision	Y	N	Dryness	Y	N
Mucous Discharge	Y	N	Redness	Y	N
Sandy or gritty feeling	Y	N	Itching	Y	N
Burning	Y	N	Foreign body sensation	Y	N
Excess tearing/watering	Y	N	Occasional tearing	Y	N
Glare/light sensitivity	Y	N	Eye pain or soreness	Y	N
Sties, chalazion	Y	N	Chronic infection of eye or lid	Y	N
Other					

Explain "Yes" answers:____

____

RESPIRATORY

Asthma	Y	N
Emphysema/COPD	Y	N
Bronchitis	Y	N
Chronic Cough	Y	N
Seasonal Allergies	Y	N
Tuberculosis	Y	N
Pneumonia	Y	N
Shortness of Breath	Y	N
Smoking History	Y	N
Other___________	Y	N

CARDIOVASCULAR

High Blood Pressure	Y	N
Low Blood Pressure	Y	N
Heart Attack	Y	N
Chest Pain/ Angina	Y	N
Heart Murmur	Y	N
Congestive Heart Failure	Y	N
Irregular Heart Beat	Y	N
Migraines	Y	N
Slow or Fast Heart Rate	Y	N
Bleeding Problems	Y	N
Stroke/TIA'S	Y	N
Other Blood or lymphatic	Y	N

Systemic

Diabetes	Y	N	Intestinal/Bowel Problems	Y	N
Thyroid	Y	N	Cancer	Y	N
Kidney Disease	Y	N	Arthritis	Y	N
Hepatitis/Yellow Jaundice	Y	N	Other Musculoskeletal	Y	N
Convulsions/Seizures/			Other Skin Problems	Y	N
Blackouts	Y	N	Other Neurological	Y	N
Hiatal Hernia	Y	N	Other Psychiatric	Y	N
Stomach Ulcers	Y	N	Other Eyes, Nose, Throat	Y	N
HIV/AIDS	Y	N	Other Gastrointestinal	Y	N
			Other Genitourinary	Y	N

Explain "Yes" answers:____

____

II. Past History

List any medications you take:____

____

List all major illnesses and injuries you have had in the past:______________________________

____

List all surgeries you have had in the past:____

____

Do You have Allergies to any Medications: Y N If "Yes", list medications and type of reaction:___

____

III. Family History

Blindness	Y	N	Relationship to You___________________
Crossed or Lazy Eye	Y	N	Relationship to You___________________
Cataract	Y	N	Relationship to You___________________
Glaucoma	Y	N	Relationship to You___________________
Macular Degeneration	Y	N	Relationship to You___________________
Retinal Detachment	Y	N	Relationship to You___________________
Arthritis	Y	N	Relationship to You___________________
Cancer	Y	N	Relationship to You___________________
Diabetes	Y	N	Relationship to You___________________
Heart Attack	Y	N	Relationship to You___________________
High Blood Pressure	Y	N	Relationship to You___________________
Other	Y	N	Relationship to You___________________

IV. Social History

Current Occupation:____

Do You Drive?	Y	N	
Do you have visual difficulty when driving?	Y	N	
Do you have a problem with night vision?	Y	N	
Have you ever tried to wear contacts?	Y	N	
Do you currently wear glasses?	Y	N	How long have you had your current pair?____
Do you drink alcohol?	Y	N	If so, how frequently?____________________
Do you smoke?	Y	N	If so, how many packs a day?______________

Please list any additional pertinent information:______________________________

Initial Review by:_______________________ Date:_________________________