

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)			
<input type="checkbox"/> driving	<input type="checkbox"/> reading	<input type="checkbox"/> sports	<input type="checkbox"/> work <input type="checkbox"/> other
Do you drink alcohol?	<input type="checkbox"/> No <input type="checkbox"/> Yes	How often?	
Do you smoke?	<input type="checkbox"/> No <input type="checkbox"/> Yes	How much?	For how long?
FAMILY HISTORY			
Is there any family history of the following? (please check) If yes, list family member:			
<input type="checkbox"/> Blindness _____	<input type="checkbox"/> Cataract _____		
<input type="checkbox"/> Glaucoma _____	<input type="checkbox"/> Diabetes _____		
<input type="checkbox"/> 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)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Minipress(prazosin)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hytrin(terazosin)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Ozempic(semaglutide)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Trulictiy(dulaglutide)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Mounjaro(tirzepatide)	<input type="checkbox"/> No	<input type="checkbox"/> 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

Lungs/Breathing

- cigarette smoker
- asthma
- bronchitis
- COPD
- emphysema
- sleep apnea CPAP: Y N
- other
- NONE

Endocrine

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

Eyes

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

Gastrointestinal

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

Cardiovascular

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

Musculoskeletal

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

Genitourinary

- STD
- urinary problems
- prostate problems
- other
- NONE

Neurological

- multiple sclerosis
- epilepsy
- other
- NONE

Skin

- eczema
- rosacea
- psoriasis
- other
- NONE

Constitutional

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

Psychiatric

- depression/anxiety
- panic disorder
- schizophrenia
- dementia/Alzheimer's
- 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: