PATIENT HISTORY FORM

Date: ______________ **Name:** ______________________________ **DOB:** ____________

Medications and Dosage: ☐ **None**

List all major illnesses or injuries: ☐ **None**

Allergies to Medications and reaction: ☐ **None**

List all eye illnesses or injuries: ☐ **None**
(lazy eye, cataract, glaucoma, macular degeneration, abrasion, etc)

List any surgeries you have had: ☐ **None** ____

____

Do you have a **family** history of (Please list the relationship of the family member to you): ☐ **None**

☐ Blindness ______________________ ☐ Macular Degeneration ______________________

☐ Glaucoma ______________________ ☐ Diabetes ______________________

TODAY, Do you currently have any problems in the following areas? If, "Yes", please explain problem.

General / Constitutional

Yes	No	
☐	☐	Fever

Respiratory

Yes	No	
☐	☐	Cough

Integumentary

Yes	No	
☐	☐	Rash

Immunologic

Yes	No	
☐	☐	Seasonal Allergies

Neurological

Yes	No	
☐	☐	Headache

Health History of:

Yes	No		Yes	No		Yes	No	
☐	☐	Hypertension	☐	☐	Diabetes	☐	☐	Cancer
☐	☐	Heart Attack year_______	☐	☐	Hypothyroid	☐	☐	Emphysema
☐	☐	High Cholesterol						

Specialists you see: ____

Explanation / Other Health Problems: ____

____

Height:______________ **Weight:**________________

Preferred Language: ____________________________

Preferred Pharmacy: ________________________________

Occupation: ____

Social History – Do you?:

Yes	No	
☐	☐	Smoke ______ packs / day Years smoked _______
☐	☐	Former Smoker? Age Stopped? _____________

☐ Male ☐ Female ___________________________

****We are required to include the following information in your Health Record by the Centers for Medicare/Medicaid Services****

Race: ☐ White ☐ Asian ☐ Decline to Answer
☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Other _______________

Ethnicity: ☐ Decline to Answer
☐ Hispanic or Latino
☐ Not Hispanic or Latino