PATIENT HEALTH HISTORY

Patient Name: _____ Primary Care Physician: _____ Date Last Seen: _____

Medical/Family History

Please list all your current medications (include over the counter, vitamins and herbal therapy): _____

_____

_____

List all major surgeries (Eye Surgery included):_____

_____

List any allergic reactions to **medications or eye drops**: _____

_____

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition	**Yourself** Yes	No		Yes	No
Cataract	▪	▪	Women- Are you pregnant?	▪	▪
Eye Turn	▪	▪	Are you breast feeding?	▪	▪
Glaucoma	▪	▪			
Macular Degeneration	▪	▪			
Retinal Detachment	▪	▪			

	Family Member Yes	No	**Relationship (Blood Relatives Only)**
Blindness	▪	▪	_____
Eye Turn	▪	▪	_____
Glaucoma	▪	▪	_____
Macular Degeneration	▪	▪	_____
Retinal Detachment	▪	▪	_____

Other:_____

Review of Systems Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic
- None
- Lupus (SLE)
- Rheumatoid Arthritis
- Environmental Allergies
- Seasonal Allergies
- Other (i.e., Latex)

Ear, Nose and Throat
- None
- Sinusitis
- Upper Respiratory Tract Infection
- Other

Gastrointestinal
- None
- Crohn's Disease
- Colitis
- Acid Reflux/Ulcer
- Other

Skin/Integumentary
- None
- Eczema
- Rosacea
- Psoriasis
- Other

Psychiatric
- None
- Depression
- Bi-Polar
- Schizophrenia
- Other

Cardiovascular
- None
- High Blood Pressure
- Heart Disease
- Stroke
- Vascular Disease
- High Blood Cholesterol

Endocrine/Glands
- None
- Diabetes
- Hormone Dysfunction
- Thyroid Dysfunction
- Other

Respiratory
- None
- Asthma
- Bronchitis
- Emphysema
- Other

Muscle/Skeletal
- None
- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis
- Other

Genital/Urinary
- None
- Urinary Tract Infection
- HIV Positive
- Herpes/Chlamydia
- Other

Hematologic/Lymphatic
- None
- Anemia
- Leukemia
- Bleeding Disorder
- Other

Neurological
- None
- Multiple Sclerosis
- Epilepsy
- Tremors
- Other

General Health
- None
- Weight loss/gain
- Fever
- Fatigue
- Trauma

Social
- Tobacco Use: Current Smoker Former Smoker
- Non-Prescription Drugs_____
- Alcohol Consumption_____
- Weight_____ Height_____

Please sign below to acknowledge that this form is current & that I have received a copy of the Notice of Privacy Practices for Dr. V.I.S:

Signature: _____ Date: _____ Reviewed by Doctor's initials: _____

Acknowledgement of Receipt of Smoking Cessation Counseling

My signature below verifies my understanding that the risks of smoking are hazardous to my overall health and eyesight.

Name of Patient (Print)_____ Signature of Patient:_____Date:_____

Signature of Patient Representative (if patient is a minor or an adult unable to sign this form)

Relationship of Patient Representative to Patient _____