

Name: _____ Date : _____

Date of Birth: _____ Please fill out this confidential health history, check any area that applies to you, and bring to your appointment. This will become part of your health record.
Page 1

Describe the reason for your visit today, include which eye (eyes) you are having a problem with, how long it has been present, if the problem is mild, moderate or severe, if there is pain or if it is causing a decrease in your vision and what makes the problem better or worse. Please use the back of this sheet if needed: _____

REVIEW OF PAST MEDICAL, FAMILY & SOCIAL HISTORY Please check every area that applies to you.

Past Medical History		Diabetes History	
Y <input type="checkbox"/> N <input type="checkbox"/> Hypertension	Y <input type="checkbox"/> N <input type="checkbox"/> TB - Active	Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes	
Y <input type="checkbox"/> N <input type="checkbox"/> Heart Disease	Y <input type="checkbox"/> N <input type="checkbox"/> TB - Inactive - History of	If yes: # of Years: _____	
Y <input type="checkbox"/> N <input type="checkbox"/> Asthma	If yes: Year: _____	Last HgA1C _____	
Y <input type="checkbox"/> N <input type="checkbox"/> Stroke	Y <input type="checkbox"/> N <input type="checkbox"/> HIV	Date: _____	
If Yes: Year: _____	Y <input type="checkbox"/> N <input type="checkbox"/> Hepatitis	Y <input type="checkbox"/> N <input type="checkbox"/> Oral Medication	
Y <input type="checkbox"/> N <input type="checkbox"/> Cancer	If yes: <input type="checkbox"/> Type A	Y <input type="checkbox"/> N <input type="checkbox"/> Insulin # of years _____	
If Yes: Type: _____	<input type="checkbox"/> Type B	Y <input type="checkbox"/> N <input type="checkbox"/> Pump	
Year: _____	<input type="checkbox"/> Type C	Y <input type="checkbox"/> N <input type="checkbox"/> Transplant	
	# of Years: _____	Y <input type="checkbox"/> N <input type="checkbox"/> Dialysis	
		Times per Week: _____	
Vaccines:	Date:	Vaccines cont.:	Date:
Y <input type="checkbox"/> N <input type="checkbox"/> Tetanus	_____	Y <input type="checkbox"/> N <input type="checkbox"/> Influenza (Flu)	_____
Y <input type="checkbox"/> N <input type="checkbox"/> Hepatitis B	_____	Y <input type="checkbox"/> N <input type="checkbox"/> Pneumovax	_____
Y <input type="checkbox"/> N <input type="checkbox"/> Other: _____	_____	Y <input type="checkbox"/> N <input type="checkbox"/> Other: _____	_____
Allergies:	Use the back of this sheet if needed.	Allergies cont.:	
List Drug / Other	Reaction:	List Drug / Other	Reaction:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Surgical History: List the type of Surgery and Year if Known: _____			

** Please list Medications on the third page

Family History: Circle any conditions your relatives are known to have or have had a history of.

Parents:	Cataract(s)	Diabetes	Glaucoma	Retina Detachment	Macular Degeneration	Blindness	Unknown N/A
Siblings:	Cataract(s)	Diabetes	Glaucoma	Retina Detachment	Macular Degeneration	Blindness	Unknown N/A
Children:	Cataract(s)	Diabetes	Glaucoma	Retina Detachment	Macular Degeneration	Blindness	Unknown N/A
Relatives:	Cataract(s)	Diabetes	Glaucoma	Retina Detachment	Macular Degeneration	Blindness	Unknown N/A
Other:	_____						

Reviewed by: _____
 Jonathan M. Hershey, M.D. Sharath C. Raja, M.D. Nicholas H. Tosi, M.D. Patrick P. Sassani, M.D.

Patient Account Number: _____ Date of Birth: _____/_____/_____ Date Reviewed: _____

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REVIEW OF PAST MEDICAL, FAMILY & SOCIAL HISTORY (cont)

Social History:

Single Married Divorced Widowed

Y N Alcohol

If yes: How Often: _____

Y N Tobacco

If yes: How Often: _____

Y N Recreational Drugs

If yes: How Often: _____

REVIEW OF SYSTEMS & PAST MEDICAL HISTORY (Please check every symptom listed if it applies to you):

Systemic

Y N Fever
Y N Fatigue
Y N Weight Change

Notes: _____

Genitourinary

Y N Kidney Stones or Disease
Y N Prostate
Y N Bladder/Bowel

Notes: _____

Gastrointestinal

Y N Crohns Disease
Y N Liver Disease
Y N Ulcer

Notes: _____

Ear / Nose /Throat

Y N Hearing Problems
Y N Ringing in the Ears
Y N Sinus Problems
Y N Sore Throat

Notes: _____

Pulmonary / Respiratory

Y N Short of Breath
Y N Asthma
Y N Bronchitis
Y N Emphysema

Notes: _____

Musculoskeletal

Y N Rheumatoid Arthritis
Y N Weakness
Y N Gout

Notes: _____

Skin / Integumentary

Y N Infection
Y N Rash
Y N Itching
Y N Skin Cancer

Notes: _____

Psychological

Y N Anxiety
Y N Panic
Y N Nervousness
Y N Depression

Notes: _____

Hematologic / Lymphatic

Y N Anemic
Y N Bruise Easily
Y N Blood Clotting Disorder
If Yes, List Med for Clotting:

Notes: _____

Neurologic

Y N Headaches/Migraines
Y N Seizures
Y N Dizziness
Y N Tremor
Y N Paralysis
Y N Dementia
Y N Stroke

If Yes, List When:

Notes: _____

Cardiovascular

Y N High Blood Pressure
Y N Chest Pain
Y N Irregular Heart Beat
Y N Congestive Heart Failure
Y N Heart Attack

If Yes, List When:

Notes: _____

Allergy / Immunologic

Y N Hay Fever
Y N Latex Allergy

Endocrine

Y N Thyroid
Y N Hormonal Disease

Notes: _____

Doctor Notes: _____

Reviewed by:

Jonathan M. Hershey, M.D.

Sharath C. Raja, M.D.

Nicholas H. Tosi, M.D.

Patrick P. Sassani, M.D.

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Confidential Health History Page 3	Patient's Medication Record (use add'l pages as needed)
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In Columns 1 thru 4, please List all Prescription and Over the Counter medications you currently take as well as any Vitamins and Herbals. Please use the current date for any for any medication. Include anything that you take on an As Needed Basis (PRN). Medication Name and Dose Examples: Coumadin 2.5mg, Hydrochlorothiazide 12.5mg, Lipitor 10mg, Nitroglycerin 0.4mg, Zocor 20mg. Over the Counter Examples: antacids, Aspirin 325mg, Ibuprofen 200mg. Vitamin & Herbal Examples: multi-vitamins, Ginko 240mg, Garlic 600mg. Please note, Columns 5, 6 and 7 are for Clinic Use. **Please answer the questions at the bottom of the page as well.**

Patient Use				Clinic Use		
1	2	3	4	5	6	7
Current Date	Name and Dose of Medication	# of Times Taken per Day (am, pm, 3 times, etc.)	How is it taken (oral, under the tongue, injection, topical patch, etc.)	Date Patient States Meds Added or Stopped	Date of MD Review (each Exam)	MD Signature or Initials

Patient Use: Additional patient information is required. Please answer the questions below.

Please list the Name, Address & Phone for your Primary Care Doctor (not eye doctor): Name: _____
 Address: _____ Phone: _____
 Do you use tobacco? Yes No If **Yes**, how long have you been a smoker? _____ yrs How many cigarettes do you smoke a day? _____
 If 65 years of age or older, have you ever had a pneumococcal vaccine injection (pneumonia vaccine)? Yes No
 Do you receive an Influenza (flu) vaccine every year? Yes No If Yes, when did you receive your last one ? _____

Clinic Use

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 Jonathan M. Hershey, M.D. Sharath C. Raja, M.D. Nicholas H. Tosi, M.D.
 Patient Name: _____ Date of Birth: ____/____/____