

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.

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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

- Y N Hypertension
- Y N Heart Disease
- Y N Asthma
- Y N Stroke
If Yes: Year: _____
- Y N Cancer
If Yes: Type: _____
Year: _____

- Y N TB - Active
- Y N TB - Inactive - History of
If yes: Year: _____
- Y N HIV
- Y N Hepatitis
If yes: Type A
 Type B
 Type C
of Years: _____

Diabetes History

- Y N Diabetes
If yes: # of Years: _____
Last HgA1C _____
Date: _____
- Y N Oral Medication
- Y N Insulin # of years _____
- Y N Pump
- Y N Transplant
- Y N Dialysis
Times per Week: _____

Vaccines:

- Y N Tetanus _____
- Y N Hepatitis B _____
- Y N Other: _____

Vaccines cont.:

- Y N Influenza (Flu) _____
- Y N Pneumovax _____
- Y N Other: _____

Allergies:

Use the back of this sheet if needed.

List Drug / Other	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

Allergies cont.:

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, MD Sharath C. Raja, MD Nicholas H. Tosi, MD Daniel D. Kim, MD Ryan N. Vogel, MD

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 Y N Tobacco Y N Recreational Drugs
If yes: How Often: _____ If yes: How Often: _____ 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: _____

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