

HEALTH AND MEDICATION INFORMATION

7-2011

Name: _____ DOB: _____ Todays date: _____

Occupation: _____ Family Dr: _____ Referring Dr: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____

Approximate Height: _____ Weight: _____ Year of last Flu shot: _____

When was your last eye exam? _____ When was your last physical? _____

Preferred Communication by: Telephone Postal Email Text Gender: Female Male

Do you wear glasses? Y N For distance only Near only Lined Bi focal, Lined Tri focal, No line Progressive

Do You wear Contacts? Y N Soft Disposable Replace lens every : day / 2 wk / month Brand: _____ Rigid CL

Are you interested in wearing contacts? Yes No Have you worn contacts in the past? Y N

Y	N	Past Medical History	Y	N	Family History	Y	N	Body System Review
		Please check Yes or No			List relationship, if Grandparent, please note			Do you now have any of these symptoms?
		High Blood Pressure			<i>maternal</i> Grandmother or <i>paternal</i> Grandmother			Cardiovascular (heart, chestpain)
		Heart Disease			High Blood Pressure			Musculoskeletal (arthritis, bone)
		Diabetes # of yrs			Heart Disease			Integumentary (skin)
		Lung Disease			Diabetes # of yrs			Gastrointestinal (stomach / bowel)
		Circulatory Disease			Lung Disease			Psychiatric (Depression...)
		Thyroid Disease			Circulatory Disease			Endocrine (Diabetes, Thyroid)
		Arthritis			Thyroid Disease			Ears, Nose, Throat Mouth
		Asthma			Arthritis			(dry mouth, Chronic cough, sinus)
		Seizures			Asthma			Respiratory
		Cancer			Seizures			(Asthma, Lung, Sleep Apnea)
		Liver Disease			Cancer			Genitourinary
		HIV Positive / Aids			Liver Disease			(bladder, sexually transmitted disease)
		Bowel Disease			HIV Positive / Aids			Neurological
		Kidney Disease			Bowel Disease			(headaches, migrains, seizures)
		Blood Transfusion			Kidney Disease			Constitutional
		Alzheimers / Dementia			Alzheimers / Dementia			(fever, weight loss, etc.)
		Psychiatric			Psychiatric			Hematologic / Lymphatic
		Elevated Cholesterol			Elevated Cholesterol			(anemia, bleeding problem)
		Other			Other			Allergic / Immunologic
								hayfever, HIV, Aids)
		Past Ocular History			Family History			Social History
		Eye Injury			Eye Surgery			Are you pregnant?
		Eye Surgery			Glaucoma			Do you smoke?
		Glaucoma			Cataracts			Have you ever smoked?
		Cataracts			Retinal Disease			Do you use alcohol?
		Retinal Disease			Crossed or Lazy eye			seldom / frequently (circle one)
		Crossed or Lazy eye						Power of Attorney - POA

Please list any Eye drops that you use: _____

Please list any Allergies to Medications: _____

Please list any Medications/ Drugs and the condition you are taking them for.		Please list any surgeries and date	
Name of Drug	Condition	Surgery	Date

Dr's signature _____ Date: _____

I have read the previous medical history and agree that it is current except for the following changes.

Change: _____ Date: _____ Signature _____ Dr. signature _____