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# Patient Health History

Name:_____ Birth Date:_____
Who is your family physician?_____
What is his/her address? _____

**Please indicate , yes or no, if you have any of the following medical conditions or symptoms:**

| Yes | No | | |
|---|---|---|---|
| ___ | ___ | **High blood pressure** | _____ |
| ___ | ___ | Heart disease | _____ |
| ___ | ___ | High cholesterol | _____ |
| ___ | ___ | **Lung Disease** | _____ |
| ___ | ___ | Asthma | _____ |
| ___ | ___ | Emphysema | _____ |
| ___ | ___ | Tuberculosis | _____ |
| ___ | ___ | **Diabetes** | _____ |
| | | □Oral medication(s) | _____ |
| | | □ Insulin | _____ |
| ___ | ___ | Kidney Disease | _____ |
| ___ | ___ | **Neurological Disease** | _____ |
| ___ | ___ | Seizures | _____ |
| ___ | ___ | Stroke | _____ |
| ___ | ___ | **Blood Disorders** | _____ |
| ___ | ___ | **Arthritis** | _____ |
| ___ | ___ | **Stomach problems** | _____ |
| ___ | ___ | Macular Degeneration | _____ |
| ___ | ___ | **Thyroid Disorder** | _____ |
| ___ | ___ | **Cancer** | _____ |
| ___ | ___ | **Glaucoma** | _____ |
| ___ | ___ | **Headaches** | _____ |
| ___ | ___ | **Double Vision** | _____ |
| ___ | ___ | **See Flashes/ Floaters** | _____ |
| ___ | ___ | **Other** | _____ |

**Please list any of the above medical conditions that any close family members have.**

| Medical Condition | Family Member |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Please list all medications that you take and how much and how often you take them.**

□ I do not take any medicine, including aspirin.

| Medication | Dose |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Please list any medications to which you are allergic.**

□ I am not allergic to any medications

| Medication | Reaction |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Please list all surgeries, including eye surgeries, that you have ever had.**

□ I have never had any surgery

| Surgical Procedure | Date |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Social History:**

Do you smoke? □ yes □ no
□ light □ moderate □heavy

Date: _____ Updated:_____

Signature:_____