PATIENT PERSONAL HEALTH HISTORY

(complete form in ink only)

Today's Date:_____

Name:_____ Sex: M F Date of Birth:_____ Age:_____

REVIEW OF SYSTEMS:

Do YOU presently have any problems in the following areas?			If Yes, Please Explain
Allergies & Immunologic	❑ Yes	❑ No	_____
Bones, joints, and muscles	❑ Yes	❑ No	_____
Cardiovascular (heart / blood vessel)	❑ Yes	❑ No	_____
Ear, Nose, Throat	❑ Yes	❑ No	_____
Gastrointestinal (stomach / intestines)	❑ Yes	❑ No	_____
Genitourinary	❑ Yes	❑ No	_____
Headaches	❑ Yes	❑ No	_____
Blood Disease	❑ Yes	❑ No	_____
Skin Disease	❑ Yes	❑ No	_____
Lymphatic (lymph nodes / swelling)	❑ Yes	❑ No	_____
Neck / Spine	❑ Yes	❑ No	_____
Neurologic System	❑ Yes	❑ No	_____
Psychiatric (depression, anxiety, breakdown)	❑ Yes	❑ No	_____
Respiratory (lungs and breathing)	❑ Yes	❑ No	_____

SPECIFIC:

____ Arthritis
____ Asthma
____ Bronchitis
____ Bleeding Tendencies
____ Cancer / Tumors
____ Chest Pain
____ Chicken Pox
____ **Diabetes - Type: 1 or 2**
When diagnosed? _____
____ Emphysema / COPD
_____ Gout
_____ Hearing Impairment
_____ Heart Disease
_____ Hemorrhoids
_____ Hepatitis / Liver Disease
_____ Hernia
_____ High Blood Pressure
_____ Kidney Stones
_____ Nervous Breakdown / Depression / Anxiety
____ ____ Neuritis
____ Rheumatic Fever
____ Stroke
____ Thyroid Disease
____ Tuberculosis
____ Ulcers (Stomach)
____ Venereal Disease
____ Other _____

ARE YOU ALLERGIC TO ANY MEDICATIONS
( ) Yes ( ) No ( ) Don't Know If Yes, Which Medicine(s)?

_____

_____

_____

SOCIAL HISTORY:

Do you use tobacco products? Never Former Current (every day) Current (occasional)

Do you drink alcohol? No Yes If yes, how much? _____

Do you use illegal drugs? No Yes If yes, how much? _____

PLEASE COMPLETE OTHER SIDE

Has anyone in your immediate **BLOOD-RELATED FAMILY** ever had:

Arthritis	_____ Yes _____ No	High Blood Pressure	_____ Yes _____ No
Blindness	_____ Yes _____ No	Kidney Disease	_____ Yes _____ No
Cancer	_____ Yes _____ No	Macular Degeneration	_____ Yes _____ No
Cataract	_____ Yes _____ No	Retinal Detachment	_____ Yes _____ No
Diabetes	_____ Yes _____ No	Stroke	_____ Yes _____ No
Glaucoma	_____ Yes _____ No	Thyroid Disease	_____ Yes _____ No
Heart Attacks	_____ Yes _____ No	Other	_____

CURRENT EYE DROPS:

Name	Dose (Mg)	Times / Day

PREVIOUS EYE SURGERIES:

Type	Place	Date

PREVIOUS GENERAL SURGERIES

Name	Place	Date

OTHER MEDICATIONS (**including OTCs & Vitamins**):

Name	Dose (Mg)	Times / Day

See attached list: Yes _____ No _____

Family Doctor: _____

Pharmacy: _____ Location: _____

Have you noticed or been told by others that your color perception is altered? (Circle one)

YES NO

Did you need assistance filling out this form because of your vision? (Circle one)

YES NO

Patient's Signature _____