Eye Care Center - Patient Health History Form

1965 11th Ave. E – Suite 101, Maplewood, MN 55109 - Phone: 651-777-3555
1202 East More Lake Dr., Fridley, MN 55432 - Phone: 763-574-0075
7880 Main St. North, Maple Grove, MN 55369 - Phone: 763-420-6981

Patient Name: ________________________________ Date of Birth: _______________ Date:_______________

Please indicate if you have medical conditions involving the following body systems and give a brief description.

	Yes	No		
1	☐	☐	Ears/Nose/Throat/Mouth Disease	____________________
2	☐	☐	Heart Conditions	____________________
3	☐	☐	High Blood Pressure	____________________
4	☐	☐	Blood Disorders	____________________
5	☐	☐	High Cholesterol	____________________
6	☐	☐	Urinary or Kidney Disease	____________________
7	☐	☐	Muscle or Joint Conditions	____________________
8	☐	☐	Skin Conditions	____________________
9	☐	☐	Stroke/Neurological Disease	____________________
10	☐	☐	Migraine Syndrome	____________________
11	☐	☐	Mental Health Conditions	____________________
12	☐	☐	Thyroid Imbalance/Disease	____________________
13	☐	☐	Seasonal Allergies	____________________
14	☐	☐	Immune system conditions	____________________
15	☐	☐	Asthma or Lung condition	____________________
16	☐	☐	Stomach/Intestinal Conditions	____________________
17	☐	☐	Diabetes	____________________
19	☐	☐	Other	____________________

Indicate if you or any of your parents, brothers, or sisters has had the following conditions and briefly describe.

20	☐	☐	Glaucoma	____________________
21	☐	☐	Macular Degeneration	____________________

22 ☐ ☐ Eye Surgery (Not inc. Cataracts) ______________________________

23 ☐ ☐ Other Eye Disease ______________________________

Do you smoke? ☐ Yes ☐ No Do you use alcohol ☐ Yes ☐ No

Medications: Please list all medications you currently take, including any over the counter meds.

____

____

____

Medication Allergies: Please list all medications that you have allergies to.

____

Who is your Primary Care Physician? Please include the clinic name, location and phone number.

____