

PATIENT HEALTH HISTORY

Please fill in the following Patient Health History Form. It will aid the doctor in giving you optimum care as it relates to your visual problems.

NAME _____ DATE _____

1. Main visual problem _____

2. Any present illness (such as colds, bronchitis, infection, etc.) in last two months?

3. Are you now or have you ever been treated for the following? (If yes, give dates.)

Heart trouble _____	Arthritis _____
Lung trouble _____	Liver Disease _____
Tuberculosis _____	Bone-joint trouble _____
Diabetes _____	Retinal Detachment _____
Glaucoma _____	Kidney trouble _____
High Blood Pressure _____	Tendency to bleed _____

If you have answered YES to any of the above please explain.

4. Previous surgeries (including eye surgeries and eye laser treatments), give dates.

5. Do you have any allergies to: _____ Aspirin
_____ Iodine
_____ Local anesthetic

6. List all the medicines you are taking _____

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7. Do you have any of the following?

- | | | |
|--|---|---|
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Chest pain | <input type="checkbox"/> History of heart attack |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dentures | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Stomach Pain | <input type="checkbox"/> Get up at night to urinate |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Blood on stool | <input type="checkbox"/> Problems with your blood |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pain with urination |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Sleep with two or more pillows | |

If YES, please explain _____

8. Family History - List any glaucoma, retinal detachment, diabetes, or high blood pressure. If deceased, also include age and cause of death.

Father _____
Mother _____
Brothers/Sisters _____

9. Please answer the following questions:

- | | | |
|--|------------------------------|-----------------------------|
| Can you see well enough to drive a car? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Can you see well enough to drive at night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Can you see well enough to read? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Can you see well enough to play golf? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Can you see well enough to recognize people? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Can you see well enough to do hobbies? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Can you see well enough to sew? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

10. Family physician (or internist): Name _____
Address _____
Phone _____

11. Your Signature _____
Your Address _____
