Patient Health History

Please complete information requested to the best of your knowledge.

Patient Name		**Date of Birth**	
Primary Care Physician		**PHARMACY**	

Review Of Systems	
Please circle or list any current illnesses, symptoms or problems	
Constitution	Chills Fatigue Fever Rash Night Sweats Weakness Weight loss
Cardiovascular	Arrhythmia Chest Pain Irregular Heart Beat Hypertension
Ears, Nose, Mouth, Throat	Dizziness Hearing Loss Sinus Pain
Respiratory / Lungs	Cough Shortness of Breath
Stomach / Intestines	Abdominal Pain Diarrhea Heartburn Nausea
Urinary / Reproductive	Pain with Urination Kidney Stones Frequent Urination
Bones / Joints / Muscles	Arthritis Back Pain Gout Joint Pain Juvenile Idiopathic Arthritis Juvenile Rheumatoid Arthritis Osteoarthritis Polymyalgia Rheumatica Sjogrens Syndrome
Skin / Hair / Nails	Basal Cell Carcinoma Skin Cancer
Neurological	Bell's Palsy Headaches Migraines
Endocrine	Diabetes Thyroid
Psychiatric	Depression Bipolar Anxiety
Blood / Circulation	Anemia Easy Bruising Excessive Bleeding
Allergic / Immunologic	Allergic Rhinitis Rheumatoid Arthritis
Other	

Past / Present Ocular History	
Please circle any past or present ocular illnesses, symptoms or problems	
Glaucoma CataractsAge-Related Macular Degeneration Eye Injury Retinal Disease Other Disease Blindness Strabismus Lazy Eye Diabetes Dry Eye Refractive	
Other	
Please list any previous eye surgeries:	

Past Medical History
Please circle any past medical conditions: Arthritis Asthma Cancer COPD Diabetes Heart Disease High Cholesterol Hypertension Kidney Disease Stroke Thyroid Problem Special Needs Other
Condition details

Patient Name: _____ Patient Date of Birth: _____

Social History: Please Answer	
Do you use recreational drugs? Yes No	**Do you use alcohol?** Yes No
Smoking status (Please circle one): **current smoker** **former smoker** **never smoked**	

Family History					
Please list any family members with these conditions	Mother	Sister	Father	Brother	Grandparent
Glaucoma			**Amblyopia**		
Cataracts			**Diabetes**		
Macular Degeneration			**Cancer**		
Eye Injury			**Heart Disease**		
Retinal Disease					
Other Disease			**Other**		
Blindness			**Other**		
Eye Turn/Strabismus			**Other**		

Allergies to Medications			
Allergy	**Onset Date**	**Reaction**	**Severity**

Medications		Pharmacy	
Please list all prescriptions, over the counter and herbal medications			
Date	**Name**	**Strength**	**Directions**

Contact Lens History			
Type of contact lenses you currently use (gas permeable, soft daily, extended)			
Average number of hours that you wear your contacts		**How often do you replace your contacts?**	
Medical Alerts			
Please list all medical alerts (i.e., Do Not Dilate, epilepsy, DNR / DNI)			