Patient Health History

Thank you for choosing our practice. To better serve you, please fill out the information below to the best of your ability.

PLEASE PRINT CLEARLY

Patient's Full Name	Date of Birth / /	Account #		
Mailing Address	City	ST	Zip Code	
Home Phone Number	Cell Phone Number			
Primary Care Doctor	Referring Doctor			
Preferred Pharmacy	Preferred Pharmacy Location			
Emergency Contact Name	Relationship	Phone Number		
Occupation (if retired, former occupation)				

Eye History

Do you currently wear: ❑ Glasses ❑ Contact Lenses ❑ Neither

Are you currently using any prescription or non-prescription medications for your eye(s)? ❑ Yes ❑ No

If yes, please list: _____

Have you every had eye surgery?

Right Eye: ❑ Yes ❑ No

Type of Surgery: _____

Date (if known): _____

Type of Surgery: _____

Date (if known): _____

Left Eye: ❑ Yes ❑ No

Type of Surgery: _____

Date (if known): _____

Type of Surgery: _____

Date (if known): _____

Medical History

Do you have or have you ever had:

1. Cardiovascular disease? ❑ Yes ❑ No
   (heart attack, coronary artery disease, angina, chest pain, irregular heart rate or palpitations, congenital heart disease, rheumatic heart disease, murmur)
2. Respiratory disease? ❑ Yes ❑ No
   (asthma, emphysema, COPD, chronic cough, bronchitis)
3. Stroke? ❑ Yes ❑ No
4. Heart surgery? ❑ Yes ❑ No
   (bypass or stent)
5. Pacemaker? ❑ Yes ❑ No
6. High blood pressure? ❑ Yes ❑ No
7. Snoring or sleep apnea? ❑ Yes ❑ No
8. Difficulty with anesthesia? ❑ Yes ❑ No
9. Bleeding disorder, anemia? ❑ Yes ❑ No
10. Liver disease? ❑ Yes ❑ No
11. Kidney disease? ❑ Yes ❑ No
12. Diabetes? ❑ Yes ❑ No
    (type 1 or type 2)
13. Thyroid disease? ❑ Yes ❑ No
14. Cancer? ❑ Yes ❑ No

Allergies

Are you allergic to any medications?

❑ No ❑ Yes If so, please list: _____

Are you allergic to latex?

❑ No ❑ Yes

(over)

Please list <u>all</u> medications you are currently taking, including over-the-counter, prescriptions and vitamins:

Medication	Dosage	Times Per Day

Review of Symptoms

Are you currently experiencing problems with any of the following?

If yes, please circle the condition(s) that apply or write in any other condition(s) in the space provided.

Heart (*chest pain, angina, irregular heart beat*) ❑ No ❑ Yes, _____

Respiratory (*coughing, wheezing, shortness of breath, asthma*) ❑ No ❑ Yes, _____

Ear/Nose/Throat (*sore throat, sinus problems, earache, hearing loss*) ❑ No ❑ Yes, _____

Gastrointestinal (*belly pain, heartburn, bowel problems, vomiting*) ❑ No ❑ Yes, _____

Urinary (*pain when urinating, blood in urine, incontinence*) ❑ No ❑ Yes, _____

Hematologic/Lymphatic (*blood disorder, bruising, cuts heal slowly*) ❑ No ❑ Yes, _____

Endocrine (*thyroid problems, chronic fatigue, weight gain/loss*) ❑ No ❑ Yes, _____

Integumentary (*rashes, dry skin, eczema*) ❑ No ❑ Yes, _____

Musculoskeletal (*joint pain, stiffness, muscle pain or weakness*) ❑ No ❑ Yes, _____

Neurological (*numbness, headaches, seizures, paralysis*) ❑ No ❑ Yes, _____

Psychiatric (*depression, anxiety, insomnia, confusion*) ❑ No ❑ Yes, _____

Allergic/Immunologic (*reaction to food, seasonal allergies*) ❑ No ❑ Yes, _____

Social History

Do you drink alcohol: ❑ Never ❑ Rarely ❑ Moderately ❑ Daily

Do you use tobacco: ❑ Never ❑ Formerly ❑ Currently

Family History

Family Relation	*Medical/Eye Disease*	*If deceased, cause of death*
Father		
Mother		
Sibling		
Sibling		
Child		
Child		

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform Dr. Saunders' office of any changes in my medical status.

_____ _____

Signature of patient or guardian *Date*