Patient Name:______________________________ Date of Birth:________________

<u>Patient Health History Form</u>

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Phillipsburg, NJ 08865

This information is confidential

Past Ocular History

Disorders		Eye Surgeries/Date
Cataracts	Y/N	______________________
Glaucoma	Y/N	______________________
Macular Degeneration	Y/N	______________________
Floaters or Flashes	Y/N	______________________
Retinal Tear/Detachment	Y/N	______________________
Crossed Eyes/Lazy Eye	Y/N	
Eye Trauma	Y/N	**Eye Medications**
Eye Infections	Y/N	______________________
Dry Eye/Sjogrens	Y/N	______________________
Lid Droop	Y/N	______________________
Blocked Tear Duct	Y/N	______________________
Contact Lenses	Y/N	______________________

Type of Contacts:____

Past Medical History

Diabetes	Y/N	Emphysema	Y/N
Type I or Type II	Y/N	Tuberculosis	Y/N
Hypertension	Y/N	Kidney Disease/Stones	Y/N
Coronary Artery Disease	Y/N	Liver Disease	Y/N
Heart Attack/Angina	Y/N	Thyroid Disease	Y/N
Congestive Heart Failure	Y/N	Sinusitis/Allergies	Y/N
Arrhythmia/A-Fib	Y/N	Hepatitis/HIV/Herpes	Y/N
Heart Blockage	Y/N	Neurological Disorders	Y/N
Asthma	Y/N	Migraines/Seizures	Y/N
Arthritis	Y/N	Anemia	Y/N
Rheumatoid Arthritis	Y/N	Elevated Cholesterol	Y/N

Past Medical Surgeries/Date

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Current Medications

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Drug Allergies

Penicillin	Y / N	Reaction ________________________
Sulfa	Y / N	Reaction ________________________
Iodine/Betadine	Y / N	Reaction ________________________
Eggs/Shellfish	Y / N	Reaction ________________________
Novocaine ETC.	Y / N	Reaction ________________________
IV Dye	Y / N	Reaction ________________________
Adhesive Tape	Y / N	Reaction ________________________
Latex	Y / N	Reaction ________________________
Erythromycin	Y / N	Reaction ________________________

Other Drug Allergies:

________________________ Reaction ________________________

________________________ Reaction ________________________

Social History

Occupation: ________________________ Marital Status: ________________________

Alcohol use: Daily/Social/None Recreational Drugs: Y / N

Any tobacco use: Current/Former/None

How much per day: ____________________

Pharmacy Name/Phone: ____

Mail order Pharmacy: ____

Family History

Ocular		Medical	
Glaucoma	Y / N	Diabetes	Y / N
Macular Degeneration	Y / N	Cancer	Y / N
Retinal Disease	Y / N	Heart Disease	Y / N
Lazy Eye	Y / N	Hypertenison	Y / N
Other: ____________________		Other: ________________	

Review of Systems

Ocular	
Blurry Vision	Y / N
Double Vision	Y / N
Pain	Y / N
Halos	Y / N
Foreign Body Sensation	Y / N
Burning/Itching	Y / N
Discharge	Y / N
Light Sensitivity	Y / N
Floaters/Flashes	Y / N
Tearing	Y / N

Ear, Nose and Throat	
Hard of Hearing	Y / N
Ringing in Ears	Y / N
Vertigo	Y / N

Constitutional	
Fatigue/Weakness	Y / N
Fever	Y / N
Weight Gain/Loss	Y / N

Skin	
Rash/Sores	Y / N
Lesions	Y / N
Hives/Eczema	Y / N
Cancer	Y / N

Cardiovascular	
Chest Pain	Y / N
Dizziness	Y / N
Fainting Spells	Y / N
Shortness of breath	Y / N
Irregular Heartbeat	Y / N
Difficulty Lying Flat	Y / N

Psychiatric	
Anxiety/Depression	Y / N
Mood Swings	Y / N

Respiratory	
Cough	Y / N
Congestion	Y / N
Wheezing	Y / N
Asthma	Y / N

Gastrointestinal	
Heartburn	Y / N
Nausea/Vomiting	Y / N
Jaundice/Hepatitis	Y / N

MusculoSkeletal	
Stiffness	Y / N
Arthritis	Y / N
Joint Pain/Swelling	Y / N

Review of Systems Continued

Genito-Urinary

Pain/Difficult	Y / N
Blood in Urine	Y / N
Kidney Stones	Y / N
History of STD's	Y / N
History of Flomax	Y / N
History of Rapaflo	Y / N

Endocrine

Increased Thrist	Y / N
Increased Hunger	Y / N
Increased Urination	Y / N
Increased Sweating	Y / N
Fingernail Changes	Y / N
History of Jalyn use	Y / N

Immunologic

Runny Nose	Y / N
Sinus Pressure	Y / N
Fever	Y / N

Blood/Lymphnodes

Bruises Easily	Y / N
Gums Bleed Easily	Y / N
Prolonged Bleeding	Y / N
Heavy Asprin Use	Y / N
Anemia	Y / N

Neurological

Seizures	Y / N
Weakness/Paralysis	Y / N
Numbness	Y / N
Tremors	Y / N