

Patient Health History

Patient Name: _____

Date: _____

Occupation: _____

Hobbies: _____

Chronic Illnesses: Please mark all **CURRENT** and **PAST** Conditions

Eyes

- | | | |
|---|--|--|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Disease | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Iritis | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Corneal Disease | <input type="checkbox"/> Any Other Eye Disorder? |

Ear, Nose, and Throat

- | | |
|----------------------------------|------------------------------------|
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Sinusitis |
|----------------------------------|------------------------------------|

Cardiovascular

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Carotid Artery Disease |
|--|--|---|---|

Respiratory

- | | | | |
|---------------------------------|------------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> COPD |
|---------------------------------|------------------------------------|---------------------------------------|-------------------------------|

Gastrointestinal

- | | | |
|------------------------------------|--------------------------------|--------------------------------------|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Gallbladder |
|------------------------------------|--------------------------------|--------------------------------------|

Genitourinary

- | | |
|---|--|
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prostate Disorder |
|---|--|

Muscles/Skeletal

- | | |
|---|-------------------------------|
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Gout |
|---|-------------------------------|

Integumentary (Skin)

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Psoriasis / Eczema | <input type="checkbox"/> Skin Cancer |
|---|--------------------------------------|

Neurologic

- | | | | |
|---------------------------------|--|---|------------------------------------|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Migraines |
|---------------------------------|--|---|------------------------------------|

Psychiatric

- | | |
|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> Alzheimer's |
|----------------------------------|--------------------------------------|

Endocrine

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Dysfunction |
|-----------------------------------|--|

Hematologic/Lymphatic

- | | |
|---------------------------------|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Other Blood Disorder |
|---------------------------------|---|

Allergy/Immune

- | | | | |
|---|---|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Sarcoid | <input type="checkbox"/> Lupus | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Other: (Explain) | | |

Family History (Has anyone in your family (blood relative) had any of the following?)

Note Relation to Patient using Abbreviation: F=Father, M=Mother, S=Sister, B=Brother, U=Uncle, A=Aunt,

P=Paternal, M=Maternal, GF=Grandfather, GM=Grandmother

- | | |
|---|--|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Amblyopia or "Lazy Eye" |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Any Other Eye Disorder |
| <input type="checkbox"/> Corneal Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Retinal Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Other General Health Problems (Explain) |

Social History Please mark all that apply

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Do you smoke? _____ Packs per day? | <input type="checkbox"/> _____ Packs per week? | |
| <input type="checkbox"/> Do you drink alcohol? _____ # per day? | <input type="checkbox"/> _____ # per month? | |
| <input type="checkbox"/> Do you use recreational drugs? | <input type="checkbox"/> (Women) Are you Pregnant or Nursing? | |
| <input type="checkbox"/> Single? | <input type="checkbox"/> Widowed? | <input type="checkbox"/> I live alone |
| <input type="checkbox"/> Married? | spouse's name | |

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