PATIENT HEALTH HISTORY **(please print)**

Referring Doctor: _____ Primary Medical Physician: _____

Date of Last Exam with Medical Physician: _____

Pharmacy #1 Name/Address/Phone: _____

Pharmacy #2 Name/Address/Phone: _____

Have you had a change in your physical condition within the past six months? YES NO

If yes, please explain: _____

Influenza Vaccine Received **YES** **NO** **Pneumonia Vaccine Received** **YES** **NO**

History Of Medical Problems

	YES	NO	How Long?		YES	NO	How Long?
Diabetes	☐	☐	_____	Cancer	☐	☐☐	_____
High Blood Pressure	☐	☐	_____	Hepatitis	☐	☐☐	_____
Heart Disease	☐	☐☐☐	_____	AIDS/HIV	☐	☐☐	_____
Respiratory Problems	☐	☐☐	_____	Kidney Dialysis	☐	☐☐	_____
Neurological Problems	☐	☐☐	_____	Rheumatoid Arthritis	☐	☐	_____
Depression/Anxiety	☐	☐☐	_____	Multiple Sclerosis	☐	☐☐	_____
Thyroid Problems	☐	☐☐	_____☐	Other: _____			

Current Medications	Dose	Frequency	Ocular History (Office Use Only)

Have you or an immediate family member ever been told you have the following eye problems? (check all that apply and circle appropriate person)

☐☐ Glaucoma self family member ☐☐ Retinal Detachment self family member

☐☐ Cataracts self family member ☐☐ Macular Degeneration self family member

☐☐ Other: _____ self family member

Past Major Surgeries (type & year): _____

_____

Allergies to Medications: _____

Other Allergies:_____ **Latex Allergy?** YES NO

Do you smoke? NO YES _____ packs per day **Have you smoked in the past?** YES NO

Alcohol Use? Never Occasionally Daily

Do you live alone? YES NO

Are you currently or have you lived in a skilled nursing facility within the past year? YES NO

Updates (for Office Use Only)

Date	Tech	Date	Tech	Date	Tech
_____	____	_____	____	_____	____
_____	____	_____	____	_____	____
_____	____	_____	____	_____	____
_____	____	_____	____	_____	____

Patient Signature: _____ Date: _____