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?
Diabetes	☐	☐	________
High Blood Pressure	☐	☐	________
Heart Disease	☐	☐	________
Respiratory Problems	☐	☐	________
Neurological Problems	☐	☐	________
Depression/Anxiety	☐	☐	________
Thyroid Problems	☐	☐	________
Other: ______________________			
Cancer	☐	☐	________
Hepatitis	☐	☐	________
AIDS/HIV	☐	☐	________
Kidney Dialysis	☐	☐	________
Rheumatoid Arthritis	☐	☐	________
Multiple Sclerosis	☐	☐	________
Pacemaker	☐	☐	________
Defibrillator	☐	☐	________

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

☐ Cataracts self family member

☐ Retinal Detachment 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

Tobacco Use? 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: ______________________