Vision Patient Health History Form

LAST NAME	FIRST NAME	DATE OF BIRTH	AGE
ADDRESS		DATE OF LAST VISION EXAM	
ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? YES NO		IF YES, FOR WHAT?	
NAME OF PRIMARY CARE PROVIDER	**PREFERRED PHARMACY**		
SPECIALIST(S) YOU ARE CURRENTLY SEEING			

GENERAL HEALTH

IS YOUR GENERAL HEALTH GOOD?	YES	NO
HAS THERE BEEN A CHANGE IN YOUR OVERALL HEALTH WITHIN THE LAST YEAR?	YES	NO
HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE LAST 3 YEARS?	YES	NO
IF YES, PLEASE EXPLAIN	DATE OF HOSPITALIZATION	
HAVE YOU BEEN DIAGNOSED WITH AN OCULAR DISEASE?	YES	NO
HAVE YOU HAD ANY EYE SURGERIES OR EYE TRAUMAS?	YES	NO
DO YOU WEAR GLASSES?	YES	NO
DO YOU WEAR CONTACT LENSES?	YES	NO

PAST AND PRESENT MEDICAL PROBLEMS (PLEASE CHECK)

CARDIOVASCULAR	EYES, EARS, NOSE & MOUTH	ENDOCRINE
HIGH BLOOD PRESSURE	EYE DISEASE	THYROID DISEASE: HYPO HYPER
HEART ATTACK	SINUS PROBLEMS	DIABETES
CHEST PAIN	**GASTROINTESTINAL**	EXCESSIVE THIRST
HEART DISEASE	FREQUENT NAUSEA/ VOMITING	DRY MOUTH
HEART MURMURS	GASTROESOPHOGEAL REFLUX	DIFFICULTY SWALLOWING
PROSTHETIC HEART VALVE	STOMACH PROBLEMS	**RHEUMATOLOGY**
CONGENITAL HEART DEFECT	ULCERS	ARTHRITIS / RHEUMATISM
PACEMAKER	LIVER DISEASE	RHEUMATIC FEVER
GENERAL	HEPATITIS: A B C	INFECTIVE ENDOCARDITIS
FEVER	**INFECTIOUS DISEASE**	ARTIFICIAL JOINT
NIGHT SWEATS	AIDS / HIV	**HEMATOLOGY**
WEIGHT GAIN	HERPES	BLEEDING PROBLEMS
WEIGHT LOSS	VD (syphilis or gonorrhea)	EASY BRUISING
URINARY	SKIN DISEASE	BLOOD TRANSFUSION
KIDNEY DISEASE	**PSYCHOLOGICAL**	ANEMIA
BLADDER DISEASE	ANXIETY	**ONCOLOGY**
PULMONARY	DEPRESSION	CANCER
ASTHMA	**NEUROLOGICAL**	TUMORS
COPD / EMPHYSEMA	DIZZINESS	CHEMOTHERAPY
SHORTNESS OF BREATH	FAINTING SPELLS	RADIATION TREATMENTS
TUBERCULOSIS	SEIZURES / EPILEPSY	**ALLERGIES**
WOMEN ONLY	HEADACHE	FOOD
PREGNANT OR NURSING	MIGRAINE	MEDICATIONS
TAKING BIRTH CONTROL PILLS	STROKE/HARDENING OF ARTERIES	LATEX

FAMILY HISTORY

DIABETES	GLAUCOMA	MACULAR DEGENERATION

SOCIAL HISTORY

RECREATIONAL DRUGS	TOBACCO (IN ANY FORM)	ALCOHOL

(Continue on Reverse)

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MEDICATION HISTORY
OCULAR MEDICATIONS:
OTHER MEDICATIONS (INCLUDING OVER THE COUNTER):
MEDICATION ALLERGIES:

SURGERIES Please list any surgeries you have had.
VISION HISTORY & SURGERIES
MEDICAL HISTORY & SURGERIES

PATIENT/GUARDIAN SIGNATURE	DATE
PSHC PROVIDER SIGNATURE	DATE