APPLE HILL EYE CENTER

HEALTH HISTORY FORM

NAME:

DATE: MEDS:
PMHx
FHx
SHx
ROS
INITIALS

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APPLE HILL EYE CENTER
HEALTH HISTORY FORM

Name:______________________________ **Date of Birth:**____________ **Date:**______________

PAST MEDICAL HISTORY:
List major illnesses (diabetes, hypertension, heart disease, etc.). Include approximate date of diagnosis.

List major surgeries and/or injuries you have had. Include the (approximate) date of each.

MEDICATIONS: List any medications you currently take.

ALLERGIES: List all allergies you have, including medications.

FAMILY HISTORY:
Does anyone in your family (blood relatives) have any eye conditions such as glaucoma, cataracts, crossed eyes, blindness? Yes ❑ No ❑
Does anyone in your family (blood relatives) have any medical conditions such as diabetes, heart disease, etc.? Yes ❑ No ❑
If yes, please list:______________________________

SOCIAL HISTORY: Occupation: (If Retired, State Last Job Held):______________________________

Do you drive? Yes ❑ No ❑ Do you smoke? Yes ❑ No ❑ How Much?__________________

Do you drink alcohol? Yes ❑ No ❑ How Much?__________________

ROS: Do you currently have any problems in the following areas? If yes, please explain below.

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Fever	❑	❑	Lungs / Breathing	❑	❑	Skin Problems	❑	❑	Anxiety
❑	❑	Weight Loss	❑	❑	Chronic Bronchitis	❑	❑	Neurologic Condition	❑	❑	Thyroid
❑	❑	Sinus Problems	❑	❑	Stomach / Intestines	❑	❑	Headaches	❑	❑	Blood/Lymph Node Disorder
❑	❑	Dry Mouth / Throat	❑	❑	Kidney / Bladder	❑	❑	Weakness	❑	❑	Seasonal Allergies
❑	❑	Heart / Blood Vessels	❑	❑	Muscle / Joint Pain	❑	❑	Depression	❑	❑	Other

Other comments you want the Doctor to know:

Patient Signature______________________________ Doctor Signature______________________________