Patient:_____ **Date of Birth:**_____ **Today's Date:**_____

Health History (Past Medical/Review of Systems)

Please circle **"YES"** if you have been **diagnosed or treated** for any of the following.

Please circle **"YES"** under Family Members to indicate if a **blood relative** has had any of the following and list relation to patient.

	Yourself	Family Members
Cataracts/Cataract Surgery	Yes	Yes
Color Vision Problem	Yes	Yes
Corneal Disease	Yes	Yes
Crossed Eyes / Lazy Eye / Amblyopia	Yes	Yes
Eye Injury / Eye Surgery	Yes	Yes
Glasses with Prism	Yes	Yes
Glaucoma	Yes	Yes
Loss of Vision / Blindness	Yes	Yes
Macular Degeneration	Yes	Yes
Retinal Disease	Yes	Yes
AIDS / HIV	Yes	Yes
Alzheimer's / Dementia	Yes	Yes
Arthritis	Yes	Yes
Artificial Heart Valve	Yes	Yes
Artificial Joints	Yes	Yes
Autoimmune Disorders	Yes	Yes
Bleeding Disorders	Yes	Yes
Cancer / Type:	Yes	Yes
Chemical Dependency	Yes	Yes
Cholesterol / Triglycerides	Yes	Yes
Depression / Anxiety	Yes	Yes
Diabetes: Type I / Type II	Yes	Yes
Ear, Nose, Throat Problems	Yes	Yes
Epilepsy / Seizures	Yes	Yes
Gastrointestinal / Acid Reflux	Yes	Yes
Hay Fever / Allergies	Yes	Yes
Heart Conditions / Problems	Yes	Yes
Hepatitis / Type:	Yes	Yes
High Blood Pressure / Hypertension	Yes	Yes
Kidney / Bladder Problems	Yes	Yes
Lupus	Yes	Yes
Migraine Headaches	Yes	Yes
Musculoskeletal Problems	Yes	Yes
Neurological Problems	Yes	Yes
Osteoporosis / Osteopenia	Yes	Yes
Pacemaker	Yes	Yes
Prostate Disease	Yes	Yes
Respiratory Problems	Yes	Yes
Rheumatic Fever	Yes	Yes
Shingles	Yes	Yes
Skin conditions	Yes	Yes
Stroke	Yes	Yes
Thyroid: High / Low / other:	Yes	Yes
Tuberculosis	Yes	Yes
Other:	Yes	Yes

Social History: Marital Status (circle) Single, Married, Widowed, Divorced

Do you drive? YES / NO **Limitations:** _____

Do you smoke? YES / NO **If YES:** occasional (or) # of packs per day_____

Do you drink Alcohol? YES / NO **If YES:** occasional #per day /week_____

Allergies to Medications:

_____

_____

_____

_____

_____

_____

Other Allergies:

_____

_____

_____

_____

Previous Surgeries:

_____

_____

_____

_____

_____

_____

_____

_____

Vaccine History:

- ☐ **Flu**
- ☐ **Pneumonia**
- ☐ **Shingrix**
- ☐ **Covid**

This area Office Use Only

Oriented to time / place

YES NO

Mood / Affect Appropriate

YES NO