



FISHKIND & BAKEWELL EYE CARE
HEALTH HISTORY & REVIEW OF SYSTEMS

Date Reviewed Tech MD/OD

Today's Date: _____

Legal Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Place of Birth: _____

Primary Care Physician: _____

Allergic to: None known Latex IV contrast dye Iodine Eggs Environmental

Medical allergies: _____

List surgeries/Year: _____

Do you wear contact lenses? NO YES If yes, type/brand: _____

Please circle any condition below with which you have been diagnosed- add comments as necessary

<u>Eyes:</u>	no problems	glaucoma injury	cataracts	macular degeneration
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<u>Cardiovascular:</u>	no problems	high blood pressure cardiac murmur pacemaker	heart attack atrial fibrillation	coronary artery disease congestive heart failure
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<u>Respiratory:</u>	no problems	asthma lung cancer	emphysema/COPD home oxygen use	tuberculosis
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<u>Endocrine:</u>	no problems	diabetes	thyroid disease	
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<u>Gastrointestinal:</u>	no problems	hepatitis A/B/C/D reflux disease	liver disease colon cancer	ulcers
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<u>Genitourinary:</u>	no problems	kidney disease prostate enlargement	dialysis prostate cancer	urinary tract infections kidney transplant
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<u>Neurologic:</u>	no problems	stroke multiple sclerosis	seizures Alzheimer's	Parkinson's disease psychiatric (list)
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<u>Heme/Immune:</u>	no problems	anemia bleeding disorder Other cancers (list)	leukemia lupus	lymphoma HIV/AIDS
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<u>Musculoskeletal:</u>	no problems	rheumatoid arthritis	osteoarthritis	osteoporosis
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<u>Dermatologic:</u>	no problems	psoriasis	eczema	rosacea
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<u>Other:</u>				
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Please continue on the other side of this page...

Please *circle* any problem below which you have had *recently*

Eyes: blurry vision, double vision, distorted vision, eye pain Other: _____

Ears/Nose/Throat: ear pain, stuffy nose, sore throat, dry mouth Other: _____

Cardiovascular: chest pain, palpitations Other: _____

Respiratory: shortness of breath, cough Other: _____

Endocrine: fatigue, hair loss Other: _____

Gastrointestinal: abdominal pain, diarrhea, constipation, blood in stool Other: _____

Genitourinary: painful urination, difficulty urinating, blood in urine Other: _____

Neurologic: headache, weakness, numbness, imbalance Other: _____

Heme/Immune: easy bruising, nosebleeds Other: _____

Musculoskeletal: joint pains, poor mobility Other: _____

Dermatologic: rash, sores Other: _____

FAMILY HISTORY- Please tell us which of your blood relatives have/had the following problems

Diabetes: _____ Heart disease: _____ High blood pressure: _____ Stroke: _____

Glaucoma: _____ Macular Degeneration: _____ Cancer (type): _____

SOCIAL HISTORY- Please tell us a bit about yourself

Occupation: _____

Hobbies/Interests: _____

Do you live alone? NO YES

Do you exercise? NO YES- type and frequency: _____

Do you drink alcohol? NO YES- type and frequency: _____

Do you smoke tobacco? NO YES- how much? _____ Age started: _____ Age quit: _____

Recreational drug use? NO YES- type and frequency: _____

Do you drive? NO YES

Please tell us who referred you to our practice: _____

Patient Signature:

Date:

Signature of person other than patient completing this form

Date: