

Health History

This information will allow us to know about your general health. This is important as many general medical problems affect the health of your eyes and vision.

Name: _____ Date: _____ Your Occupation: _____ DOB: _____

Please check all of the following items that are currently bothering you.

Constitutional: None
 Fatigue Weakness
 Fever Weight Loss
 Night Sweats Weight Gain

Heart: None
 Exophthalmos Sinus Problems
 Hearing Loss Sore Throat
 Hoarseness Tinnitus
 Lump in Neck Vertigo
 Nasal Congestion

Respiratory: None
 Asthma Dyspnea on Exertion
 Cough Hemoptysis
 Dyspnea Wheezing

Cardiovascular None
 Arrhythmia Irregular Heartbeat / Palpitations
 Calf Pain Leg Swelling
 Chest Pressure / Discomfort Tachycardia

Gastrointestinal: None
 Abdominal Pain Food Intolerance
 Black tarry Stools Heartburn
 Constipation Increased Appetite
 Decreased Appetite Jaundice
 Diarrhea Nausea
 Dysphagia Vomiting

Genitourinary: None
 Dysuria Irregular Menses
 Genital Lesions Urethral Discharge
 Hematuria Urgency

Metabolic / Endocrine: None
 Cold Intolerance Polyphagia
 Heat Intolerance Polyuria
 Polydipsia

Neurological: None
 Balance Disturbances Headache
 Dizziness Memory Difficulty
 Focal Weakness Numbness of

Psychiatric: None
 Depressed Mood Insomnia
 Emotional Changes Irritability
 Euphoria Nervousness
 Frequent Nightmares Stress
 Hallucinations

Integumentary: None
 Abnormal Hair Distribution Skin Changes
 Dry Skin Skin Lesion
 Hives Skin Nodules
 Itching Skin Skin Sores
 Nail Changes Ulcer
 Rash

Musculoskeletal: None
 Arthralgia Joint Stiffness
 Back Pain Joint Swelling
 Fracture Muscle Cramping
 Gait Disturbance Muscle Weakness

Hematologic / Lymphatic: None
 Bleeding Lymphadenopathy
 Bruising Tender Lymph Nodes

Immunologic: None
 Environmental Allergies Food Allergies
 Seasonal Allergies

The main reason for your appointment today: _____

Do you wish information on:

LASIK? Yes No
 COSMETIC? Yes No
 HEARING? Yes No

Thank you for your support and being a loyal patient!