PATIENT HEALTH HISTORY

Thank you for choosing our practice. To better serve you, please fill out the information below to the best of your ability.

Patient Name _____ Sex _____ Birth Date _____
Primary Care Physician _____
Occupation _____ Email _____

EYE HISTORY

When was your last eye exam? Where? _____
Do you currently wear: ☐ Glasses ☐ Contact lenses ☐ Neither
Do you have difficulty seeing: ☐ Far Away ☐ Up Close (with glasses if you have them)
☐ Other _____
Are you currently using any prescription or non-prescription medications for your eyes? ☐ Yes ☐ No
If yes, please list _____
_____
Have you ever had eye surgery? ☐ Yes ☐ No
If yes, please list _____
_____
Have you ever injured your eye(s)? ☐ Yes ☐ No
If yes, please list _____
_____

Do you have any of the following eye conditions?

	Yes	No	Currently	Family		Yes	No	Currently
Glaucoma	☐	☐	☐	☐	Blur	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	Redness	☐	☐	☐
Cataracts	☐	☐	☐	☐	Itching	☐	☐	☐
Retinal tear or detachment	☐	☐	☐	☐	Burning	☐	☐	☐
Lazy eye	☐	☐	☐	☐	Dryness	☐	☐	☐
Floating Spots in eye (s)	☐	☐	☐		Crusting	☐	☐	☐
Flashes of light in eye(s)	☐	☐	☐		Discharge	☐	☐	☐
Double Vision	☐	☐	☐		Eye Pain	☐	☐	☐

Social History

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Use of Alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Use of Tobacco ☐ Never ☐ Yes, but not in the past _____ years ☐ Yes _____ packs/day

Medical History

Are you currently being treated for any of the following?
☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Other _____
Please list any medications you currently take, prescription or non-prescription _____
_____

Patient Name _____

Do you have:

Drug Allergies ☐ Yes _____ ☐ No

Food Allergies ☐ Yes _____ ☐ No

Are you currently experiencing problems with any of the following? (If Yes, please specify on line)

Sudden weight gain or loss ☐ Yes ☐ No _____

Heart ☐ Yes ☐ No _____
(Example: chest pain, **hypertension**, irregular heart beat)

Respiratory ☐ Yes ☐ No _____
(Example: coughing, wheezing, asthma)

Ear/Nose/Throat ☐ Yes ☐ No _____
(Example: sore throat, sinus problem, earache)

Gastrointestinal ☐ Yes ☐ No _____
(Example: abdominal pain, vomiting, heartburn)

Urinary ☐ Yes ☐ No _____
(Example: pain when urinating, blood in urine)

Hematologic/Lymphatic ☐ Yes ☐ No _____
(Example: blood disorders, bruising easily, **cholesterol**)

Endocrine ☐ Yes ☐ No _____
(Example: **diabetes**, thyroid problems)

Integumentary ☐ Yes ☐ No _____
(Example: rashes, dry skin)

Musculoskeletal ☐ Yes ☐ No _____
(Example: joint pain, stiffness or swelling)

Neurological ☐ Yes ☐ No _____
(Example: numbness, headache, seizures)

Psychiatric ☐ Yes ☐ No _____
(Example: depression, anxiety, insomnia)

Allergic/Immunologic ☐ Yes ☐ No _____
(Example: seasonal allergies)

I have accurately answered all questions on this form to the best of my ability. I have been offered a copy of Dr. Smrkovski's privacy policies (HIPAA). I also understand that I am financially responsible for my charges if my insurance does not cover the costs of my exam.

_____ _____

Patient Signature (or Parent/Guardian) Date

_____ _____

Physician Signature Date

All previous medical history remains accurate. There have been no changes.

Patient Signature:	Date:	Physician Signature:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____