

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. (rev 3.5.08)

Name: _____ Date: _____ Your Occupation: _____

Please **circle** any of the following items that are bothering you. If no problems circle **NONE**.

<p><u>Constitutional:</u> NONE</p> <p>Headaches Fatigue</p> <p>Fever Weakness</p> <p>Insomnia Weight gain</p> <p>Weight loss</p> <p><u>Ear, Nose, Throat:</u> NONE</p> <p>Hearing loss Vertigo</p> <p>Ringing in the ears Hoarseness</p> <p>Sinus problems</p> <p>Nasal congestion</p> <p>Sore throat</p> <p><u>Respiratory:</u> NONE</p> <p>Shortness of breath Asthma</p> <p>Wheezing Cough</p> <p>Pain with breathing</p> <p>Blood in sputum</p> <p>TB exposure</p> <p><u>Cardiovascular:</u> NONE</p> <p>Palpitations</p> <p>Rapid heart rate</p> <p>Irregular heart rhythm</p> <p>Chest pain or pressure</p> <p>Shortness of breath with exertion</p> <p>Calf pain with exercise</p> <p>Leg swelling</p>	<p><u>Gastrointestinal:</u> NONE</p> <p>Abdominal pain Black stools</p> <p>Constipation Diarrhea</p> <p>Decreased appetite Heart burn</p> <p>Food intolerance Jaundice</p> <p>Increased appetite Nausea</p> <p>Trouble swallowing Vomiting</p> <p><u>Genitourinary:</u> NONE</p> <p>Urinary discharge Urinary urgency</p> <p>Pain with urination Blood in urine</p> <p>Abnormal menstruation Genital sores</p> <p><u>Integumentary:</u> NONE</p> <p>Skin color change Skin rash</p> <p>Skin lump Itchy skin</p> <p>Dry skin Skin ulcer</p> <p>Abnormal hair change Hives</p> <p>Abnormal finger nails Sores</p> <p>Abnormal lesions</p> <p><u>Endocrine:</u> NONE</p> <p>Bulging eyes</p> <p>Cold intolerance</p> <p>Heat intolerance</p> <p>Increased thirst</p> <p>Increased urination</p> <p>Mass in front of neck</p>	<p><u>Neurological:</u> NONE</p> <p>Balance problems Dizziness</p> <p>Fainting Headaches</p> <p>Local weakness Seizures</p> <p>Memory problems Tingling</p> <p>Numbness of extremities</p> <p>Tremors Vertigo</p> <p><u>Psychological:</u> NONE</p> <p>Nervousness Tension</p> <p>Low mood Irritability</p> <p>Excessively elevated mood</p> <p>Hallucinations</p> <p><u>Musculoskeletal:</u> NONE</p> <p>Joint pains Joint stiffness</p> <p>Back pain Muscle pain</p> <p>Muscle wasting Night cramps</p> <p>Easily broken bones</p> <p><u>Hematological:</u> NONE</p> <p>Enlarged lymph nodes Bleeding</p> <p>Tender lymph nodes Bruising</p> <p>Blood transfusion</p> <p><u>Immunological:</u></p> <p>Hives</p> <p>Seasonal allergies</p>
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Any other important information? _____

Do you wish information on LASIK? _____

The main reason for your appointment today: _____

Your health insurer (HMO, etc.) has contractually defined a routine eye exam. A routine eye exam is performed as a service to patients when their only complaint is related to glasses or contact lenses or when patients wish to be screened for eye diseases, such as glaucoma, without any symptoms. Insurance coverage for a routine eye exam will be denied if there are any other complaints or problems (headaches, tearing, irritation, red eyes, etc.), general medical problems requiring an eye exam (diabetes, arthritis, etc.), or medications requiring an eye exam (steroids, plaquenil, etc.). Should there be any eye problems or symptoms not related to the need for glasses or contact lenses, then a referral from your primary care physician may be required to obtain proper insurance coverage for your visit. It is the patient's responsibility to inquire from his/her insurance companies the specific eligibility requirements and frequency allowed for a routine eye exam. If any medical problems are discovered on your routine eye exam, further evaluation of these problems may have to be made on subsequent visits after the appropriate referral, or if you prefer, at the time of your routine eye examination but you will be required to pay for the additional services provided.