

## 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: \_\_\_\_\_

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

<p><b>Constitutional:</b> <input type="checkbox"/>None</p> <p><input type="checkbox"/>Fatigue      <input type="checkbox"/>Weakness</p> <p><input type="checkbox"/>Fever          <input type="checkbox"/>Weight Loss</p> <p><input type="checkbox"/>Night Sweats   <input type="checkbox"/>Weight Gain</p> <hr/> <p><b>Heent:</b> <input type="checkbox"/>None</p> <p><input type="checkbox"/>Exophthalmos   <input type="checkbox"/>Sinus Problems</p> <p><input type="checkbox"/>Hearing Loss    <input type="checkbox"/>Sore Throat</p> <p><input type="checkbox"/>Hoarseness      <input type="checkbox"/>Tinnitus</p> <p><input type="checkbox"/>Lump in Neck    <input type="checkbox"/>Vertigo</p> <p><input type="checkbox"/>Nasal Congestion</p> <hr/> <p><b>Respiratory:</b> <input type="checkbox"/>None</p> <p><input type="checkbox"/>Asthma          <input type="checkbox"/>Dyspnea on Exertion</p> <p><input type="checkbox"/>Cough           <input type="checkbox"/>Hemoptysis</p> <p><input type="checkbox"/>Dyspnea        <input type="checkbox"/>Wheezing</p> <hr/> <p><b>Cardiovascular</b> <input type="checkbox"/>None</p> <p><input type="checkbox"/>Arrhythmia      <input type="checkbox"/>Irregular Heartbeat / Palpitations</p> <p><input type="checkbox"/>Calf Pain        <input type="checkbox"/>Leg Swelling</p> <p><input type="checkbox"/>Chest Pressure / Discomfort   <input type="checkbox"/>Tachycardia</p>	<p><b>Gastrointestinal:</b> <input type="checkbox"/>None</p> <p><input type="checkbox"/>Abdominal Pain   <input type="checkbox"/>Food Intolerance</p> <p><input type="checkbox"/>Black tarry Stools   <input type="checkbox"/>Heartburn</p> <p><input type="checkbox"/>Constipation      <input type="checkbox"/>Increased Appetite</p> <p><input type="checkbox"/>Decreased Appetite   <input type="checkbox"/>Jaundice</p> <p><input type="checkbox"/>Diarrhea          <input type="checkbox"/>Nausea</p> <p><input type="checkbox"/>Dysphagia        <input type="checkbox"/>Vomiting</p> <hr/> <p><b>Genitourinary:</b> <input type="checkbox"/>None</p> <p><input type="checkbox"/>Dysuria          <input type="checkbox"/>Irregular Menses</p> <p><input type="checkbox"/>Genital Lesions    <input type="checkbox"/>Urethral Discharge</p> <p><input type="checkbox"/>Hematuria        <input type="checkbox"/>Urgency</p> <hr/> <p><b>Metabolic / Endocrine:</b> <input type="checkbox"/>None</p> <p><input type="checkbox"/>Cold Intolerance   <input type="checkbox"/>Polyphagia</p> <p><input type="checkbox"/>Heat Intolerance   <input type="checkbox"/>Polyuria</p> <p><input type="checkbox"/>Polydipsia</p> <hr/> <p><b>Neurological:</b> <input type="checkbox"/>None</p> <p><input type="checkbox"/>Balance Disturbances   <input type="checkbox"/>Headache</p> <p><input type="checkbox"/>Dizziness        <input type="checkbox"/>Memory Difficulty</p> <p><input type="checkbox"/>Focal Weakness    <input type="checkbox"/>Numbness of</p>	<p><b>Psychiatric:</b> <input type="checkbox"/>None</p> <p><input type="checkbox"/>Depressed Mood    <input type="checkbox"/>Insomnia</p> <p><input type="checkbox"/>Emotional Changes   <input type="checkbox"/>Irritability</p> <p><input type="checkbox"/>Euphoria          <input type="checkbox"/>Nervousness</p> <p><input type="checkbox"/>Frequent Nightmares   <input type="checkbox"/>Stress</p> <p><input type="checkbox"/>Hallucinations</p> <hr/> <p><b>Integumentary:</b> <input type="checkbox"/>None</p> <p><input type="checkbox"/>Abnormal Hair Distribution   <input type="checkbox"/>Skin Changes</p> <p><input type="checkbox"/>Dry Skin          <input type="checkbox"/>Skin Lesion</p> <p><input type="checkbox"/>Hives            <input type="checkbox"/>Skin Nodules</p> <p><input type="checkbox"/>Itching Skin      <input type="checkbox"/>Skin Sores</p> <p><input type="checkbox"/>Nail Changes     <input type="checkbox"/>Ulcer</p> <p><input type="checkbox"/>Rash</p> <hr/> <p><b>Musculoskeletal:</b> <input type="checkbox"/>None</p> <p><input type="checkbox"/>Arthralgia        <input type="checkbox"/>Joint Stiffness</p> <p><input type="checkbox"/>Back Pain        <input type="checkbox"/>Joint Swelling</p> <p><input type="checkbox"/>Fracture         <input type="checkbox"/>Muscle Cramping</p> <p><input type="checkbox"/>Gait Disturbance   <input type="checkbox"/>Muscle Weakness</p> <hr/> <p><b>Hematologic / Lymphatic:</b> <input type="checkbox"/>None</p> <p><input type="checkbox"/>Bleeding         <input type="checkbox"/>Lymphadenopathy</p> <p><input type="checkbox"/>Bruising         <input type="checkbox"/>Tender Lymph Nodes</p> <hr/> <p><b>Immunologic:</b> <input type="checkbox"/>None</p> <p><input type="checkbox"/>Environmental Allergies   <input type="checkbox"/>Food Allergies</p> <p><input type="checkbox"/>Seasonal Allergies</p>
<p>The main reason for your appointment today: _____</p> <p>_____</p>		
<p>Do you wish information on:</p> <p style="padding-left: 40px;">LASIK? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="padding-left: 40px;">COSMETIC? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="padding-left: 40px;">HEARING? Yes <input type="checkbox"/> No <input type="checkbox"/></p>		

Thank you for your support and being a loyal patient!