Malouf Eye Center

Health History

(All information on this form is strictly confidential)

***Please answer ALL questions**

Name: _____ **DOB:** _____ **Today's Date:** _____

Reason for your visit today: _____

Patient Health History:

Yes	No		Yes	No	
❑	❑	Arthritis	❑	❑	Anxiety
❑	❑	Atrial Fibrillation (Irregular Heartbeat)	❑	❑	Asthma
❑	❑	COPD	❑	❑	Cancer: Type? _____
❑	❑	Diabetes: _____# yrs ▫ Insulin? YES NO	❑	❑	Depression
❑	❑	Hepatitis	❑	❑	Hearing Loss
❑	❑	High Cholesterol	❑	❑	Heart Disease
❑	❑	Hyperthyroidism	❑	❑	High Blood Pressure
❑	❑	Lymphoma	❑	❑	Hypothyroidism
❑	❑	Radiation Treatment	❑	❑	HIV / AIDS
❑	❑	Stroke	❑	❑	Migraines
			❑	❑	Seizures

❑ ❑ *(Women) Are you pregnant or nursing?

❑ ❑ Rheumatologic Disease: Lupus, RA, Sarcoid, etc.

❑ Other: _____

List ALL medications:

(including eye drops)

Medications	Dosage	Frequency

Medication ALLERGIES:

_____

_____

Ocular History:

Yes	No		Yes	No	
❑	❑	Glasses	❑	❑	Amblyopia (Lazy Eye)
❑	❑	Contact Lenses	❑	❑	Blepharitis
❑	❑	Cataracts	❑	❑	Diabetic Retinopathy
❑	❑	Dry Eyes	❑	❑	Eye Trauma/Injury
❑	❑	Floaters/Flashing Lights	❑	❑	Glaucoma
❑	❑	Iritis	❑	❑	Macular Degeneration

❑ Other: _____

Social History:

Smoking Status: ❑ Never ❑ Current ❑ Former

Do you drink alcohol? ❑ YES ❑ NO

If YES, how many days in the past year have you had **5** or more drinks in a day for **MEN**, (or **4** or more drinks in a day for **WOMEN OR ANY ADULT OVER 65**)?: _____ days

Surgical History:

Please include date and type of ALL other surgeries:

_____

_____

_____

Family History:

Do any medical or eye diseases run in your family?

❑ Glaucoma ❑ Macular Degeneration

❑ Diabetes ❑ High Blood Pressure ❑ Cancer

❑ Other: _____

Review of Systems:

Do you CURRENTLY have any of the following?

❑ Poor vision	❑ Eye Pain	❑ Tearing	❑ Redness	❑ Fever	❑ Fatigue	❑ Weight loss/gain
❑ Stuffy nose	❑ Ear ache	❑ Dry mouth	❑ Chest Pain	❑ Cough	❑ Congestion	❑ Hard of hearing
❑ Wheezing	❑ Joint pain	❑ Stiffness	❑ Diarrhea	❑ Constipation	❑ Palsy	❑ Rapid heartbeat
❑ Arthritis	❑ Skin	❑ Eczema	❑ Dermatitis	❑ Rash	❑ Diabetes	❑ Thyroid abnormalities
❑ Stroke	❑ Seizure	❑ Migraine	❑ Anxiety	❑ Depression	❑ Upset stomach	❑ Shortness of breath

❑ Other: _____