Family Focus EYE CARE

PATIENT HEALTH HISTORY

Name:_____ Date:_____

SELF – HEALTH HISTORY / ROS

Primary Care Physician:_____ Clinic:_____

Constitutional Symptoms

Developmental Disability	No	Yes
Recent Weight Change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Shortness of Breath	No	Yes
Cancer	No	Yes

Onset Date:_____
Comment:_____

Ears/Nose/Mouth/Throat

Chronic Sinus Problems	No	Yes
Hearing Loss	No	Yes
Dry Mouth	No	Yes
Laryngitis	No	Yes
Sinusitis	No	Yes

Onset Date:_____
Comment:_____

Neurological

Multiple Sclerosis	No	Yes
Epilepsy	No	Yes
Cerebral Palsy	No	Yes
Tumor	No	Yes
Stroke, CVA	No	Yes
Migraine	No	Yes

Onset Date:_____
Comment:_____

Psychiatric

Depression	No	Yes
Nervousness/Panic Disorder	No	Yes
Schizophrenia	No	Yes
Attention Deficit	No	Yes
Anxiety Disorder	No	Yes
Bipolar Disorder	No	Yes

Onset Date:_____
Comment:_____

Cardiovascular

Heart Disease	No	Yes
High Blood Pressure	No	Yes
Stroke	No	Yes
Vascular Disease	No	Yes
Congestive Heart Failure	No	Yes

Onset Date:_____
Comment:_____

Respiratory

Asthma	No	Yes
Bronchitis	No	Yes
Emphysema	No	Yes
Cigarette Smoker	No	Yes
Chronic Obstruction	No	Yes
Sleep Apnea	No	Yes

Onset Date:_____
Comment:_____

Gastrointestinal

Crohn's Disease	No	Yes
Ulcer	No	Yes
Colitis		
Acid Reflux		
Celiac Disease		

Onset Date:_____
Comment:_____

Genitourinary

Urinary Tract Infections	No	Yes
Kidney Disease	No	Yes
STDs (HIV, herpes, chlamydia)	No	Yes
Prostate Disease/Cancer		
Pregnant		
Nursing		

Onset Date:_____
Comment:_____

Musculoskeletal

Arthritis	No	Yes
Fibromyalgia	No	Yes
Muscular Dystrophy	No	Yes
Ankylosing Spondylitis		
Osteoporosis		
Gout		

Onset Date:_____
Comment:_____

Integumentary

Eczema	No	Yes
Rosacea	No	Yes
Psoriasis	No	Yes
Herpes Simplex/Cold Sores	No	Yes
Herpes Zoster/Shingles	No	Yes

Onset Date:_____
Comment:_____

Endocrine

Type2 Diabetes	No	Yes
Type 1 Diabetes	No	Yes
Thyroid Dysfunction	No	Yes
Hormonal Dysfunction	No	Yes

Onset Date:_____
Comment:_____

Hematologic/Lymphatic

Anemia	No	Yes
Large Volume Blood Loss	No	Yes
Ulcer	No	Yes
Hypercholesteremia	No	Yes

Onset Date:_____
Comment:_____

Allergic/Immunologic

HIV/AIDS	No	Yes
Lupus	No	Yes
Environmental/Food Allergy	No	Yes
Rheumatoid Arthritis	No	Yes
Sjogrens Syndrome	No	Yes

Onset Date:_____
Comment:_____

MEDICATION TABLE

*If a medication list is available please provide, or have the front desk make a copy.

Medications and Supplements	For Condition	Dosage	Date Begun

PATIENT DRUG ALLERGIES OR SENSITIVITIES

_____

SELF – OCULAR HISTORY

Date of previous eye exam: _____

Cataract..... No Yes
Glaucoma..... No Yes
Macular Degeneration..... No Yes
Blindness..... No Yes
Retinal Detachment..... No Yes

Injury to Eye or Head..... No Yes
Ocular Foreign Body Removed... No Yes
Explain_____
Amblyopia (lazy eye)..... No Yes
Strabismus (eye turn)..... No Yes

Eye Infections..... No Yes
Other_____
Eye Surgery..... No Yes
Explain_____
_____

SOCIAL HISTORY

Circle one of the following

Alcohol Use: Never Rarely Moderate Daily

Tobacco Use: Never Previous Yes, Type:_____ How Often:_____

FAMILY (blood relatives) HEALTH HISTORY

			Family Member				Family Member
Cataract.....	No	Yes	_____	Diabetes.....	No	Yes	_____
Glaucoma.....	No	Yes	_____	High Blood Pressure.....	No	Yes	_____
Macular Degeneration.....	No	Yes	_____	Heart Problems/Stroke....	No	Yes	_____
Blindness.....	No	Yes	_____	Thyroid Problems.....	No	Yes	_____
Retinal Detachment.....	No	Yes	_____	Cancer.....	No	Yes	_____
Other_____			_____	Arthritis.....	No	Yes	_____

List any other Health Problems that run in your family _____

_____