PATIENT HEALTH HISTORY

NAME: ______________________ AGE: __________ DATE: __________
HEIGHT ______________ WEIGHT ______________

ALLERGIES: ________
Reaction: Rash _____ Hives _____ Shortness of Breath _____ Nausea _____ Other: _____
Do you Smoke: YES _____ NO _____ Quantity __________ How Many Years _____
Do you drink Alcohol: YES _____ NO _____ Quantity __________ Frequency _____

ROUTINE MEDICATIONS (PLEASE INCLUDE EYE DROPS): ***Please include list if available***

Name of Medication	Amount Taken (dosage)	How Often

MEDICAL HISTORY (CHECK IF APPLICABLE)

	WEIGHT LOSS		**GASTROINTESTINAL**		**ENDOCRINE**
	Amount: _____ Since: _____		Hiatal Hernia		Diabetes Onset: _____
	EAR/NOSE/THROAT		Ulcer		Insulin or Non Insulin
	Chronic Cough		**GENITOURINARY**		Kidney Disease
	Hayfever		Bladder Problems		Liver Disease
	Hard of Hearing		Kidney Stones		Thyroid Disease
	Hearing Aid R L		**NEUROLOGICAL**		**CANCER**
	CARDIAC		Multiple Sclerosis		(Please be specific)
	Congestive Heart Failure		Stroke		
	Irregular Heart Beat		Paralysis: (Please be specific)		**OCULAR**
	Heart Attack Year: _____				Cataract Surgery: R L
	High Blood Pressure		**MUSCULOSKELETAL**		Laser Surgery: R L
	Pacemaker		Arthritis		Strabismus Surgery: R L
	RESPIRATORY		Back Pain		Macular Degeneration: R L
	Asthma		**HEMATOLOGIC**		Glaucoma: R L
	Bronchitis		Anemia		Retinal Problems: R L
	Chronic Obstructive Pulmonary Disease		Cirrhosis		**OTHER**
	Emphysema		Hepatitis		Other
			Jaundice		
			SKIN		Other
			(Please be specific)		

First Glasses at age: _____ First Glasses were needed for: Distance Vision _____ Near Vision _____ Astigmatism _____
Have you or anyone in your family had any unusual reaction to Anesthesia: __________

PAST SURGERIES (INCLUDE DATES): __________