HEALTH HISTORY FORM

Name ____ Date _________ / _________ / __________
Address ____ Phone (home) ______________________________
City ________________________________ State ___________ Zip ________ Phone (cell) _________________________________
Guardian (if applicable) ____ Email ____________________________________
Birthdate _________ / _________ /_________ Preferred Method of Contact home / text / email
Occupation _________________________________
Last Eye Exam ________ / ________ / __________ Last Medical Exam _________ / _________ / __________
Primary Care Physician Name and Number ____

Medical History

Do you have allergies to medication? ☐ No ☐ Yes If yes, explain ____
____
List medications you take (including oral contraceptives, aspirin, over-the-counter medications, vitamins, home remedies)
____
____
List all major injuries, surgeries, and/or hospitalizations ____
____

Are you pregnant and/or nursing? ☐ No ☐ Yes
Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? _______________________
Do you wear contact lenses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? _______________________
Have you experienced any of the following?

	No	Yes	?		No	Yes	?
Flashes	☐	☐	☐	Itching	☐	☐	☐
Floaters	☐	☐	☐	Burning	☐	☐	☐
Double Vision	☐	☐	☐	Redness	☐	☐	☐
Loss of Vision	☐	☐	☐	Excess Tearing/Watering	☐	☐	☐
Blurred Vision	☐	☐	☐	Glare/Light Sensitivity	☐	☐	☐
Halos	☐	☐	☐	Infection of Lids/Styes	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐	Tired Eyes	☐	☐	☐

Are you interested in discussing the option of laser vision correction with Dr. Lam? ☐ No ☐ Yes

Family History

Please note any family history for the following conditions:

Disease/Condition	No	Yes	?	Relationship		No	Yes	?	Relationship
Amblyopia (lazy eye)	☐	☐	☐	____________	Cancer	☐	☐	☐	____________
Blindness	☐	☐	☐	____________	Diabetes	☐	☐	☐	____________
Strabismus (eye turn)	☐	☐	☐	____________	Heart Disease	☐	☐	☐	____________
Cataract	☐	☐	☐	____________	High Blood Pressure	☐	☐	☐	____________
Glaucoma	☐	☐	☐	____________	Kidney Disease	☐	☐	☐	____________
Macular Degeneration	☐	☐	☐	____________	Thyroid Disease	☐	☐	☐	____________
Retinal Disease	☐	☐	☐	____________	Other	☐	☐	☐	____________

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SOCIAL HISTORY – This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I prefer to discuss my Social History information directly with the doctor.

Do you drive? ☐ No ☐ Yes If yes, do you have difficulty when driving? ☐ No ☐ Yes

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long ________________________________

Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long ________________________________

Do you use recreational drugs? ☐ No ☐ Yes If yes, type/amount/how long ________________________________

Hobbies / Interests? ____

Review of Systems

Do you currently, or have you ever had, any problems in the following areas:

	No	Yes	?
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Integumentary			
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Endocrine			
Diabetes	☐	☐	☐
Thyroid/Other Glands	☐	☐	☐
Ear, Nose, Mouth, Throat			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Allergic/Immunologic			
Autoimmune Disease	☐	☐	☐
Increased Sensitivity	☐	☐	☐

	No	Yes	?
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Vascular/Cardiovascular			
High Blood Pressure	☐	☐	☐
Heart Disease	☐	☐	☐
High Cholesterol	☐	☐	☐
Gastrointestinal			
Gastric Reflux	☐	☐	☐
Chronic Diarrhea	☐	☐	☐
Genitourinary			
Genitals/Kidney/Bladder	☐	☐	☐
Musculoskeletal			
Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic/Hematologic			
Anemia	☐	☐	☐
Blood Disorders	☐	☐	☐
Psychiatric			
Depression	☐	☐	☐
Anxiety	☐	☐	☐

If a condition was not listed, please indicate and list medications:

____

____

____

Patient Signature ____ Date _______ / ________ / _______