Health History

Please identify any medical condition(s) which you or your close relatives may have. Please make an "X" for any body system in which you have had or currently have a diagnosed disease and or symptoms. **Note that you should answer for disorder, please mark an "X" under the "None" column.

General Health/Review of Systems

SYSTEM	EXAMPLES	Self Past	Self Now	Relative	None
1. Skin	Psoriasis, eczema, acne, rosacea, rashes				
2. Neuro/psychiatric	Multiple sclerosis, mental probs, dizziness, stroke				
3. Musculo-skeletal	Arthritis, lupus, osteoporosis, fibromyalgia				
4. Gastro-Intestinal	Colitis, pancreatitis, stomach ulcers, acid reflux				
5. Endocrine	Diabetes, thyroid disease, high cholesterol				
6. Respiratory	Asthma, bronchitits, COPD, pneumonia				
7. Genito-Urinary	Kidney failure, gynecologic disease, BPH, ED				
8. Cardio-Vascular	High blood pressure, heart disease, arrhythmias				

For any condition you marked in General Health other than "None", please write the system number and give a brief description of the disease or symptoms you or your relative have had/currently have (e.g., "5-Type II diabetes-mother"):

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Do you have allergies? Yes_____ No _____

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Please list any medication (prescription or over-the-counter) that you currently take, along with dosages, etc.

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Have you had any surgery or serious illnesses? If so, please list ______________________________

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Do you currently smoke? _____ Have you smoked in the past, but quit? _____ If so, for how long and how much? (e.g., 1 pack per day for 10 years) ____

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Do you drink alcohol? _____ If so, what do you drink and how much? __________________________

For females of child-bearing age: Are you pregnant or trying to become pregnant? Yes _____ No _____

Are you currently nursing? Yes _____ No _____

Primary Physician Name: _________________ Phone: ________________ Date of last physical: ___________

Date of your last complete eye exam _________________ Doctor's name ________________________

Do you wear glasses? __________ Contact lenses? ___________

Eye Health

EYE/VISION PROBLEMS	Self Past	Self Now	Relative	None
1. itching				
2. redness				
3. pain				
4. discharge				
5. dry eyes				
6. glaucoma				
7. cataracts				
8. macular degeneration				
9. "flashes, floaters"				
10. other				

Any specific concerns/questions about your eyes/vision? ______________________________________

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We request payment in full for services at the time they are provided, except for amounts billed to your insurance carrier(s). We are happy to bill your insurance company for you, but insurance quotes are not a guarantee of payment and you will be responsible for any allowable charges your insurance does not cover. We accept cash/checks and credit cards (Visa, MasterCard, and Discover) for payment. Please note that there is a $25 charge for NSF checks.

Signed ____ Date ___________________________

Please circle one: I'm the patient/I'm parent/guardian