



HEALTH HISTORY

Dr. Stefani S. Martin

Patient Name: _____ Date: _____

Date of Last Eye Examination: _____ Date of Last Physical Examination: _____

Primary Care Physician's Name _____ PCP Telephone _____

PCP Address _____

Do you..... (check all that apply)

<input type="checkbox"/> Work at a computer? _____ hours per week	<input type="checkbox"/> Want information on Vision Correction surgery? (Lasik)
<input type="checkbox"/> Have sensitivity to face products/eye creams?	<input type="checkbox"/> Think you might benefit from thinner, lighter lenses?
<input type="checkbox"/> Have an East/West Commute?	<input type="checkbox"/> Have family members in need of eye care?
<input type="checkbox"/> Prefer Holistic Health Care?	<input type="checkbox"/> Want to try colored contacts?
<input type="checkbox"/> Do you plan on getting glasses today?	<input type="checkbox"/> Spend time outdoors? _____ hours per week

Please circle any hobbies that you enjoy:

Reading Video Games Boating Fishing Snorkel/Scuba Golf Tennis Cycling Walking Other

Please circle Yes (Y) if you have or have ever had the following conditions or No (N) if you have not.

Ocular / Eye <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma <input type="checkbox"/> Y <input type="checkbox"/> N Cataracts <input type="checkbox"/> Y <input type="checkbox"/> N Macular Degeneration <input type="checkbox"/> Y <input type="checkbox"/> N Previous Eye Injury <input type="checkbox"/> Y <input type="checkbox"/> N Previous Eye Surgery <input type="checkbox"/> Y <input type="checkbox"/> N Excessive Burning <input type="checkbox"/> Y <input type="checkbox"/> N Excessive Itching <input type="checkbox"/> Y <input type="checkbox"/> N Excessive Tearing <input type="checkbox"/> Y <input type="checkbox"/> N Seeing Floating Spots <input type="checkbox"/> Y <input type="checkbox"/> N Seeing Flashing Lights <input type="checkbox"/> Y <input type="checkbox"/> N Double Vision <input type="checkbox"/> Y <input type="checkbox"/> N Eye Turn / Lazy Eye <input type="checkbox"/> Y <input type="checkbox"/> N Other:		Musculoskeletal <input type="checkbox"/> Y <input type="checkbox"/> N Osteoarthritis <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatoid Arthritis <input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis <input type="checkbox"/> Y <input type="checkbox"/> N Other:		Gastrointestinal <input type="checkbox"/> Y <input type="checkbox"/> N Loss Of Appetite <input type="checkbox"/> Y <input type="checkbox"/> N Cancer <input type="checkbox"/> Y <input type="checkbox"/> N Other:	
Constitutional Symptoms (General Health) <input type="checkbox"/> Y <input type="checkbox"/> N Fever <input type="checkbox"/> Y <input type="checkbox"/> N Weight Loss <input type="checkbox"/> Y <input type="checkbox"/> N Other:		Skin <input type="checkbox"/> Y <input type="checkbox"/> N Itching <input type="checkbox"/> Y <input type="checkbox"/> N New Growths on Face <input type="checkbox"/> Y <input type="checkbox"/> N Other:		Respiratory <input type="checkbox"/> Y <input type="checkbox"/> N Asthma <input type="checkbox"/> Y <input type="checkbox"/> N Chronic Bronchitis <input type="checkbox"/> Y <input type="checkbox"/> N Wheezing <input type="checkbox"/> Y <input type="checkbox"/> N Shortness Of Breath <input type="checkbox"/> Y <input type="checkbox"/> N Other:	
Endocrine (Hormones) <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N Other:		Neurological <input type="checkbox"/> Y <input type="checkbox"/> N Seizures <input type="checkbox"/> Y <input type="checkbox"/> N Headache <input type="checkbox"/> Y <input type="checkbox"/> N Muscular Sclerosis <input type="checkbox"/> Y <input type="checkbox"/> N Other:		Genitourinary <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Stones <input type="checkbox"/> Y <input type="checkbox"/> N Prostate Cancer <input type="checkbox"/> Y <input type="checkbox"/> N Other:	
Ears, Nose, Mouth, Throat <input type="checkbox"/> Y <input type="checkbox"/> N Deafness <input type="checkbox"/> Y <input type="checkbox"/> N Sinusitis <input type="checkbox"/> Y <input type="checkbox"/> N Other:		Cardiovascular <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure <input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain <input type="checkbox"/> Y <input type="checkbox"/> N Heart Valve Disease <input type="checkbox"/> Y <input type="checkbox"/> N Previous Heart Attack <input type="checkbox"/> Y <input type="checkbox"/> N High Cholesterol <input type="checkbox"/> Y <input type="checkbox"/> N Previous Stroke <input type="checkbox"/> Y <input type="checkbox"/> N Other:		Allergic / Immunologic <input type="checkbox"/> Y <input type="checkbox"/> N Allergies <input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune Disease <input type="checkbox"/> Y <input type="checkbox"/> N HIV / AIDS <input type="checkbox"/> Y <input type="checkbox"/> N Other:	
Blood / Lymphatic <input type="checkbox"/> Y <input type="checkbox"/> N Anemia <input type="checkbox"/> Y <input type="checkbox"/> N Breast Cancer <input type="checkbox"/> Y <input type="checkbox"/> N Other:		Psychiatric <input type="checkbox"/> Y <input type="checkbox"/> N Depression <input type="checkbox"/> Y <input type="checkbox"/> N Panic Attacks <input type="checkbox"/> Y <input type="checkbox"/> N Anxiety <input type="checkbox"/> Y <input type="checkbox"/> N Other:			

Please list your current medications: _____

Please list any allergies to medications: _____

Does anyone in your family have any of the following (please circle all that apply):

Glaucoma Macular Degeneration Eye Turn/Lazy Eye Diabetes High Blood Pressure

Relationship: _____