SOUTHSIDE
EYECARE & OPTICAL

HEALTH HISTORY

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Patient Name ______________________________ ***Date*** ________________

Review of Systems: (Past or Present Illness)

Eyes
Wear glasses/contacts yes/no
Eye or eye lid infection yes/no
Glaucoma yes/no
Other eye problems yes/no
Macular Degeneration yes/no

Ears, Nose, Mouth, Throat
Ear trouble yes/no
Deafness or decreased hearing yes/no
Sinus trouble yes/no
Strep throat history yes/no

Cardiovascular Problems
Chest pain yes/no
Irregular or fast heartbeat yes/no
High blood pressure yes/no
Heart attack yes/no
Arteriosclerosis (hardening of arteries) yes/no
Heart murmur yes/no
Other heart condition yes/no
Stroke yes/no

Respiratory
Shortness of breath yes/no
Bronchitis yes/no
Emphysema yes/no
Pneumonia yes/no
Allergies________________ yes/no
Asthma yes/no
Tuberculosis or exposure yes/no
Other lung problems yes/no

Gastrointestinal
Stomach/duodenal ulcer yes/no
Reflux/GERD yes/no
Diverticulosis yes/no
Colitis yes/no
Other bowel problem yes/no
Liver trouble yes/no
Gallbladder trouble yes/no
Hernia yes/no
Hemorrhoids yes/no

Genitourinary
Kidney or bladder disease yes/no
Prostate problem yes/no
Gonorrhea, Syphilis, Genital Herpes (circle which one) yes/no
Loss of control bladder or bowel yes/no

Skin Problems
Skin infections yes/no
Skin lesions yes/no
Recent tattoos yes/no
Eczema yes/no
Psoriasis yes/no
Recent piercing yes/no

Musculoskeletal
Arthritis (type___________) yes/no
Bone/joint infection yes/no
Artificial joint yes/no
Bone Tumor/cyst yes/no
Gout yes/no

Neurological Problems
Headaches yes/no
Head injury yes/no
Convulsions, seizures yes/no
Paralysis of limbs yes/no

Psychiatric
Mental problems yes/no
Nervous breakdown yes/no
Depression yes/no

Endocrine
Thyroid disease yes/no
Diabetes yes/no
Insulin dependent yes/no

Hematological/Lymphatic
Bleeding/bruising tendency yes/no
Blood clotting problems yes/no
Anemia yes/no
Phlebitis yes/no
Hepatitis (Type:) yes/no

Other problems
Recent weight change yes/no
Migraines yes/no
Cancer yes/no
Anesthesia problems yes/no
HIV yes/no

Social History:

Tobacco Use: ☐ None ☐ Chew ☐ Cigar ☐ Pipe ☐ Cigarettes Packs/day _______ #of years_______ Year quit _______
Alcohol use: ☐ Yes ☐ No Average # drinks per Day Week Year (circle one) ________ Type: ☐ Beer ☐ Wine ☐Hard Liquor
Recreational drugs: ☐ Yes ☐ No Type(s)____
Have you had a problem with alcohol or drugs? ☐Yes ☐No Been through a treatment program? ☐ Yes ☐ No ☐ N/A

Family History:

Mark which relative(s) have had the following health problems by placing a letter beside the problem
Code: M-mother, F- father, O-other, B-brother, S-sister, G-grandparent, C-child

____________ Anemia
____________ Bleeding disorder
____________ Asthma
__________ Chronic lung disease
____________ Tuberculosis
___________ High blood pressure
____________ Heart disease
____________ Convulsions/fits
____________ Thyroid problems
____________ Cancer
__________ Anesthesia problems
____________ Diabetes

____________ Stroke
____________ Ulcers
____________ Migraines
____________ Obesity
___________ Rheumatoid Arthritis
____________ Glaucoma
____________ Gout
____________ Epilepsy
____________ Mental Problems
________Macular Degeneration

Immediate Family

Family Member	Age (age of death)	List cause of death
Father	______	__________
Mother	______	__________
Sisters	______	__________
Brothers	______	__________
Children	______	__________

Patient/Parent/Guardian Signature ______________________________ **Date** ___________

Physician Signature ____ **Date** ___________

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Patient Name ______________________________ Date ______________
Height ______________ Weight ______________
General Physician______________________________

Please check all that apply

- ☐ Blurred near vision
- ☐ Blurred distant vision
- ☐ Crossed eyes
- ☐ Discharge
- ☐ Double vision
- ☐ Dry eyes
- ☐ Eye injury
- ☐ Eye strain
- ☐ Floaters or spots
- ☐ Fluctuating vision
- ☐ Foreign body
- ☐ Itching/watering
- ☐ Light sensitivity
- ☐ Migraines/headaches
- ☐ Poor night vision
- ☐ Red eyes
- ☐ See halos/flashes
- ☐ Temporary vision loss
- ☐ Twitching lid

Do you wear glasses? (circle all that apply)

never / seldom / always / T.V / driving / reading / other

Do you wear contact lenses? YES / NO

Type: Hours per day:

List any problems you are experiencing with your contact lenses or glasses:

Do you have any other complaints?

Medication & dosages ______________

____

____

Medication Allergies ______________

____

Surgeries ______________

____

____

____

____

To the fullest of my knowledge, I have accurately and truthfully completed my health and eye history.

______________________ ______________
Patient's signature (or parent/legal guardian) Date

______________________ ______________
Physician's Signature Date