Personal Health History Intake Form

Please complete all information on this form to the best of your knowledge.
If you have any questions, please ask the front desk. All information will remain confidential.

Name____ Date of Birth_____________ Today's Date____________

Address______________________________________ City_______________ State______ Zip_______________

Home Phone_____________________ Work Phone______________________ Cell Phone____________________

Email Address______________________________ Social Security No._________________________________

Medical Doctor______________________________________ Marital Status_____________________________

Occupation_____________________________ Please Circle One: Full Time Part Time Retired

How did you hear about our office? Social Media Newspaper Radio Word of Mouth Other_________

Eye Medications (eye drops, vitamins, etc.)____

Medications____
____

Prior Eye Surgeries____

Do you smoke? Y N If yes, how many packs per day?_____ If yes, for how long have you smoked?_________

Do you drink alcohol? Y N If yes, how many drinks per week?_____ Do you use recreational drugs? Y N

Height_______ Weight_______ Do you wear glasses? Y N Do you wear contact lenses? Y N

Do you currently or have you previously had any problems in the following areas? **If yes, please explain**.

Drug allergies or other allergies	Y N	____
Cardiovascular (heart, blood pressure, etc.)	Y N	____
Endocrine (diabetes, thyroid, etc.)	Y N	____
Gastrointestinal (ulcers, acid reflux, etc.)	Y N	____
Genitourinary (bladder, prostate, etc.)	Y N	____
Head (ear, nose, throat, etc.)	Y N	____
Hematologic (blood disorders, etc.)	Y N	____
Integumentary (skin, etc.)	Y N	____
Muscles, Bones, Joints (arthritis, etc.)	Y N	____
Neurological (multiple sclerosis, etc.)	Y N	____
Psychiatric (anxiety, depression, etc.)	Y N	____
Respiratory (asthma, bronchitis, etc.)	Y N	____