MIDWEST EYE CENTER, S.C.
HEALTH HISTORY FORM

NAME: _____ DATE: _____

BIRTHDATE: _____ SEX: ☐ MALE ☐ FEMALE

REASON FOR VISIT: _____

_____

ALLERGIES: ☐ NO ☐ YES _____

SOCIAL HABITS: ☐ ALCOHOL ☐ SMOKING _____ PACK/DAY ☐ SUSTANCE ABUSE

MEDICAL HISTORY **(CHECK ALL BOXES THAT APPLY TO YOU)**:

- ☐ A.I.D.S
- ☐ ARTHRITIS
- ☐ ASTHMA / BREATHING PROBLEMS
- ☐ BLEEDING DISORDER
- ☐ CANCER
- ☐ CIRCULATORY PROBLEMS
- ☐ DIABETES
- ☐ EPILEPSY
- ☐ HEART DISEASE
- ☐ HEPATITIS (WHICH TYPE_____)
- ☐ HIGH BLOOD PRESSURE
- ☐ KIDNEY DISEASE
- ☐ LIVER DISORDER
- ☐ SINUS PROBLEMS
- ☐ THYROID DISEASE
- ☐ ULCER
- ☐ OTHER _____

PLEASE LIST ALL EYE DISEASES AND / OR SYMPTOMS YOU HAVE OR HAD IN THE PAST:

- ☐ CATARACTS
- ☐ GLAUCOMA
- ☐ BLURRED VISION
- ☐ CROSSED EYE
- ☐ DIZZINESS/FAINTING
- ☐ DOUBLE VISION
- ☐ EYE INJURY
- ☐ FLOATERS
- ☐ FLASHES OF LIGHT
- ☐ HALOS
- ☐ HEADACHES
- ☐ LOSS OF VISION
- ☐ SENSITIVITY TO LIGHT
- ☐ OTHER _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING EYE MEDICATIONS:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

PLEASE LIST ALL OF THE SURGERIES YOU HAVE HAD IN THE PAST:

_____

_____

HAS ANYONE IN YOUR FAMILY HAVE/HAD ANY OF THE FOLLOWING DISEASE? PLEASE STATE WHO

- ☐ BLINDNESS _____
- ☐ CATARACTS _____
- ☐ DIABETES _____
- ☐ GLAUCOMA _____
- ☐ HYPERTENSION _____
- ☐ OTHER _____

THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND IS ONLY FOR THE USE IN MY TREATMENT/DIAGNOSIS.

_____ _____

(DATE) (SIGNATURE)