

PATIENT HEALTH HISTORY

Patient Name: _____ DOB ____/____/____ Gender: M F
 Primary Care Physician: _____ Date Last Seen: _____ Occupation: _____

Medical/Family History (use back sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins and herbal therapy): _____

List all major surgeries (Eye Surgery included): _____

List allergic conditions :(e.g. medications, seasonal, mold, dust, latex, eye drops): _____

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition

Yourself

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Cataract
 Eye Turn
 Glaucoma
 Macular Degeneration
 Retinal Detachment

Women are you Pregnant?
 Are you breast feeding?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Family Member

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Blindness
 Eye Turn
 Glaucoma
 Macular Degeneration
 Retinal Detachment

Relationship (Blood Relatives Only)

Other: _____

Review of Systems

Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic

None
 Lupus (SLE)
 Rheumatoid Arthritis
 Environmental Allergies
 Other

Ear, Nose and Throat

None
 Sinusitis
 Upper Respiratory Tract Infection
 Other

Gastrointestinal

None
 Crohn's Disease
 Colitis
 Acid Reflux/Ulcer
 Other

Skin

None
 Eczema
 Rosacea
 Psoriasis
 Other

Psychiatric

None
 Depression
 Bi-Polar
 Schizophrenia
 Other

Cardiovascular

None
 High Blood Pressure
 Heart Disease
 Stroke
 Vascular Disease
 High Blood Cholesterol

Endocrine/Glands

None
 Diabetes
 Hormone Dysfunction
 Thyroid Dysfunction
 Other

Respiratory

None
 Asthma
 Bronchitis
 Emphysema
 Other

Muscle/Skeletal

None
 Arthritis
 Fibromyalgia
 Ankylosing Spondylitis
 Other

Genital/Urinary

None
 Urinary Tract Infection
 HIV Positive
 Herpes/Chlamydia
 Other

Hematologic/Lymphatic

None
 Anemia
 Leukemia
 Bleeding Disorder
 Other

Neurological

None
 Multiple Sclerosis
 Epilepsy
 Tremors
 Other

General Health

None
 Weight loss/gain
 Fever
 Fatigue
 Trauma

Social

Tobacco Use: _____
 Current Smoker Former Smoker
 Non-Prescription Drugs _____
 Alcohol Consumption _____
 Weight _____ Height _____

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____ Reviewed by Doctor's initials: _____

Acknowledgement of Receipt of Notice of Privacy Practices

My signature below verifies that I have received a copy of the Henry Ford Health System Notice of Privacy Practices for **Henry Ford OptimEyes**.

Name of Patient (Print) _____ Signature of Patient: _____ Date: _____

Signature of Patient Representative (if patient is a minor or an adult unable to sign this form)

Relationship of Patient Representative to Patient _____