Fishkind, Bakewell, Maltzman, Hunter & Associates
*Eye Care & Surgery Center*

Today's Date:_____

## HEALTH HISTORY & REVIEW OF SYSTEMS

Legal Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Place of Birth: _____

Primary Care Physician:_____

Allergic to: None known Latex IV contrast dye Iodine Eggs Environmental

Medication allergies/Reaction:_____

List surgeries/Year: _____

Mobility status: Ambulatory Wheelchair Walker Unable to bear weight

Do you wear contact lenses? NO YES If yes, type/brand: _____

**Please *circle* any condition below with which you have been diagnosed- add comments as necessary**

| | | | | |
|---|---|---|---|---|
| Eyes: | no problems | glaucoma<br>injury | cataracts | macular degeneration |
| Cardiovascular: | no problems | high blood pressure<br>cardiac murmur<br>pacemaker<br>stent (If so, current cardiologist:_____) | heart attack<br>atrial fibrillation | coronary artery disease<br>congestive heart failure |
| Respiratory: | no problems | asthma<br>lung cancer | emphysema/COPD<br>home oxygen use | tuberculosis |
| Endocrine: | no problems | diabetes | thyroid disease | |
| Gastrointestinal: | no problems | hepatitis A/B/C/D<br>reflux disease | liver disease<br>colon cancer | ulcers |
| Genitourinary: | no problems | kidney disease<br>prostate enlargement | dialysis<br>prostate cancer | urinary tract infections<br>kidney transplant |
| Neurologic: | no problems | stroke<br>multiple sclerosis | seizures<br>Alzheimer's | Parkinson's disease<br>psychiatric (list) |
| Heme/Immune: | no problems | anemia<br>bleeding disorder<br>Other cancers (list) | leukemia<br>lupus | lymphoma<br>HIV/AIDS |
| Musculoskeletal: | no problems | rheumatoid arthritis | osteoarthritis | osteoporosis |
| Dermatologic: | no problems | psoriasis | eczema | rosacea |
| Other: _____ | | | MRSA | |

***Please continue on the other side of this page…***

**Please *circle* any problem below which you have had *recently***

| | | |
|---|---|---|
| Eyes: | blurry vision, double vision, distorted vision, eye pain | Other:_____ |
| Ears/Nose/Throat: | ear pain, stuffy nose, sore throat, dry mouth | Other:_____ |
| Cardiovascular: | chest pain, palpitations | Other:_____ |
| Respiratory: | shortness of breath, cough | Other:_____ |
| Endocrine: | fatigue, hair loss | Other:_____ |
| Gastrointestinal: | abdominal pain, diarrhea, constipation, blood in stool | Other:_____ |
| Genitourinary: | painful urination, difficulty urinating, blood in urine | Other:_____ |
| Neurologic: | headache, weakness, numbness, imbalance | Other:_____ |
| Heme/Immune: | easy bruising, nosebleeds | Other:_____ |
| Musculoskeletal: | joint pains, poor mobility | Other:_____ |
| Dermatologic: | rash, sores | Other:_____ |

**FAMILY HISTORY- Please tell us which of your blood relatives have/had the following problems**

Diabetes: _____ Heart disease: _____ High blood pressure: _____ Stroke: _____

Glaucoma: _____ Macular Degeneration: _____ Cancer (type): _____

**SOCIAL HISTORY- Please tell us a bit about yourself**

Occupation: _____

Hobbies/Interests: _____

Marital Status: Single Married Divorced Widowed

Emergency Contact: _____ Phone#: _____

Do you exercise? NO YES- type and frequency: _____

Do you drink alcohol? NO YES- type and frequency: _____

Do you smoke tobacco? NO YES- how much? _____ Age started: _____ Age quit: _____

Recreational drug use? NO YES- type and frequency: _____

Do you drive? NO YES

Please tell us who referred you to our practice: _____

_____ _____

**Patient Signature:** **Date:**

_____ _____

**Signature of person other than patient completing this form** **Date:**