GENEVA EYE CLINIC PATIENT HEALTH HISTORY

Patient Name: _____ **Date:** _____

Your Medical History

Please check any of the following conditions which you have been diagnosed with at the present time or in the past. Explain if needed.

Cardiovascular

Y	N	
☐	☐	High blood pressure _____
☐	☐	High cholesterol _____
☐	☐	Carotid Artery Disease _____
☐	☐	Heart Attack _____
☐	☐	Heart Disease _____
☐	☐	Other: _____

Neurological

Y	N	
☐	☐	Headaches ☐ Migraines _____
☐	☐	Stroke _____
☐	☐	MS _____
☐	☐	Parkinson's ☐ Alzheimer's _____
☐	☐	Developmental Delay _____
☐	☐	Other: _____

Musculoskeletal

Y	N	
☐	☐	Rheumatoid Arthritis _____
☐	☐	Other: _____

Immunologic

Y	N	
☐	☐	Lupus _____
☐	☐	HIV/ AIDS _____
☐	☐	Other: _____

Gastrointestinal

Y	N	
☐	☐	Hepatitis _____
☐	☐	Crohn's _____
☐	☐	Other: _____

Endocrine

Y	N	
☐	☐	Thyroid: ☐ Hypo ☐ Hyper
☐	☐	Diabetes: ☐ Insulin ☐ Oral Meds ☐ Diet
		How long: _____
☐	☐	Other: _____

Infections

Y	N	
☐	☐	Chicken Pox _____
☐	☐	Measles _____
☐	☐	Mumps _____
☐	☐	Shingles _____
☐	☐	MRSA _____
☐	☐	Other: _____

Other

Y	N	
☐	☐	Cancer – Type _____
☐	☐	Psychiatric Disorder _____
☐	☐	Autism _____
☐	☐	ADHD _____
☐	☐	Scarring Keloids _____

Do You

Y	N	
☐	☐	Smoke? How much? _____
☐	☐	Drink? How much? _____
☐	☐	Use recreational drugs? _____
☐	☐	Live alone? _____

Preferred Pharmacy:

Name: _____

Phone# _____

City _____ State _____

Ethnicity: **(Select one) Hispanic/Latino** ☐ **Non Hispanic/Latino** ☐

Race: **(Select one) White** ☐ **Black or African American** ☐ **Alaska Native** ☐ **Asian** ☐

American Indian ☐ **Native Hawaiian/other Pacific Islander** ☐ **Other** ☐ **Decline to answer** ☐

Primary Care Physician _____ **City** _____

Referred By _____ **City** _____

Endocrinologist/Diabetic Dr. _____ **City** _____

Other Doctor _____ **City** _____

Patient Name: _____

Your Eye History

Please check any of the following conditions which you have been diagnosed with at the present time or in the past. Explain if needed.

Y	N		
☐	☐	Glaucoma	_____
☐	☐	Cataracts	_____
☐	☐	Macular Degeneration	_____
☐	☐	Diabetic Retinopathy	_____
☐	☐	Corneal Disease	_____
☐	☐	Retinal Detachment	_____
☐	☐	Retinitis Pigmentosa	_____
☐	☐	Iritis / Uveitis	_____
☐	☐	Temporal Arteritis	_____
☐	☐	Crossed Eyes / Lazy Eye	_____
☐	☐	Eye Injury	_____
☐	☐	Contact Lens Wearer	_____
☐	☐	Other Eye Problems Not Listed	_____

_____

Your Family History

Please list the family member who has any of the following conditions (mother, father, siblings etc.)

Y	N		
☐	☐	Glaucoma	_____
☐	☐	Cataracts	_____
☐	☐	Macular Degeneration	_____
☐	☐	Corneal Disease	_____
☐	☐	Diabetic Retinopathy	_____
☐	☐	Retinal Detachment	_____
☐	☐	Crossed Eyes / Lazy Eye	_____
☐	☐	Other Eye Problems	_____
☐	☐	Diabetes	_____
☐	☐	Heart Conditions	_____
☐	☐	Stroke	_____
☐	☐	Other Health Problems	_____

_____

Your Eye Surgeries

Please list any eye surgeries, injections, lasers or treatments you have had. Please include the eye treated and the date or year it was done.

Surgery: **Eye:** **Date:**

_____

_____

_____

_____

Your Eye Drops and Eye Medications

Please list any eye drops or eye medications you are using even if it is non-prescription. Please include the dosage. Please include eye vitamins.

☐ I do not currently take any eye drops, eye medications or eye vitamins

_____

_____

_____

_____

_____

Your Medications

Please list any medications (not eye medications) that you are using even if it is non-prescription. Please include the dosage.

☐ I do not currently take any medications, vitamins or nutritional / herbal supplements

_____

_____

_____

_____

_____

_____

_____

_____

Your Allergies

Please list any allergy to medications that you have and what happened when you took it.

_____

_____

_____

_____

_____

Your General Surgeries

Please list any surgical procedures you have had. Please include the approximate date it was done.

_____

_____

_____

_____

For internal office use only

Tech Signature:_____ **Date:**_____

This form was downloaded and printed off the genevaeye.com website. Please bring it with you to your appointment.