

Omni Eye Specialists
 A Madison Street Company® Proudly Owned by Employees
Health History Form

MR # _____

Name: _____

Today's Date: _____

Occupation: _____

Date of Birth: _____

Date of last eye exam: _____

List all **medications** you currently take (Rx and over-the-counter):

Do you have **allergies** to any medications? **YES** **NO**

If YES, list the medications: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

List any **surgeries** you have had (cataract, appendectomy):

Have you previously had **LASIK** or **PRK**? **YES** **NO**

Do you **currently** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			

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Do you *currently* have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			
Do you have an allergic reaction to LATEX?			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) ? NONE UNKNOWN

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other inheritable disease: _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? YES NO

Have you ever had a blood transfusion? YES NO

Do you drink alcohol?.....YES NO If YES, how much? _____

Do you smoke?.....YES NO If YES, how much? _____ How many years? _____

POWER OF ATTORNEY

Do you have Power of Attorney documents? YES NO

If yes, please provide the contact name _____

Contact's phone number(s) _____

OFFICE USE ONLY:

Physician's Signature _____ *Date* _____