

# Omni Eye Specialists Health History Form

MR # \_\_\_\_\_

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of last eye exam: \_\_\_\_\_

List any **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):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you **currently** have any problems in the following areas?

If YES, please provide additional information.

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

**TURN PAGE OVER**

## Omni Eye Specialists Health History Form cont.

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

	YES	NO	Details
<b>MUSCLES, BONES, JOINTS</b> (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
<b>SKIN</b> (pimples, warts, growths, rash, etc.)			
<b>NEUROLOGICAL</b> (numbness, headache, seizures, paralysis, etc.)			
<b>PSYCHIATRIC</b> (anxiety, depression, insomnia)			
<b>ENDOCRINE</b> (diabetes, hypothyroid, etc.)			
<b>BLOOD / LYMPH</b> (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
<b>ALLERGIC / IMMUNOLOGIC</b> (sneezing, swelling, redness, itching, hives, lupus, etc.)			

### FAMILY HISTORY

(Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) ?	YES	NO	UNKNOWN
<b>Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis</b>			
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? _____

### OFFICE USE ONLY:

*Physician's Signature* \_\_\_\_\_ *Date* \_\_\_\_\_