

# The Eye Doctors, Inc. Patient Health History Form

Please indicate if you have medical conditions affecting the following systems and give a brief description:

Yes    No

- |                          |                          |                                |       |
|--------------------------|--------------------------|--------------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | Ear/Nose/Throat/Mouth Disease  | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Conditions               | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure            | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol               | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary or Kidney Disease      | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle or Joint Conditions     | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin Conditions                | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke/Neurological Conditions | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental Health Conditions       | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Conditions             | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever, Weight Loss/Gain        | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Immune System Conditions       | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma or Lung Conditions      | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach/Intestinal Conditions  | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                       | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                         | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia/Blood Disorders         | _____ |

Please indicate if you or any of your parents, brothers or sisters has had the following conditions:

- |                          |                          |   |       |
|--------------------------|--------------------------|---|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma  | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Macular Degeneration                                    | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye Surgery   | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes  | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use tobacco products? If yes, describe amount:   | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcohol? If yes, describe amount:          | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use recreational drugs? If yes, describe amount: | _____ |

Please list any medications, including over the counter medications, you currently take:

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Please list any known allergies to medications:

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