SOMERS EYE CENTER PATIENT HEALTH HISTORY

Name _____ Date _____

Please state the reason(s) for your visit _____

Duration of symptoms/problems _____ Referred by _____

Allergies to medications _____

Current medications _____

_____

Social History: Smoke Y N Packs per day _____

Alcohol intake: None Occasional Daily Amount _____

Past Medical History: (check if applicable)

Diabetes	_____	Asthma/lung disease	_____	Hearing problem	_____
High blood pressure	_____	Digestive disorder	_____	Thyroid disease	_____
Heart disease	_____	Psychiatric disorder	_____	Arthritis	_____
Blood disorder	_____	High cholesterol	_____	Stroke	_____
Liver disease	_____	Skin disease	_____	Seizures	_____
Migraine headaches	_____	Cancer	_____	Skin	_____

Please list any surgeries or hospitalizations with the date of occurrence

_____

_____

Past Eye History: (check if applicable)			Right	Left	Year
Glasses	_____	Cataract Surgery	_____	_____	_____
Cataracts	_____	Retinal detachment	_____	_____	_____
Retinal disease	_____	Laser Surgery	_____	_____	_____
Macular degeneration	_____	Corneal transplant	_____	_____	_____
Glaucoma	_____	Refractive Surgery	_____	_____	_____

Family History: (please indicate (P) parents (S) siblings (C) children if any relatives have the following medical conditions)

Diabetes	_____	Arthritis	_____
Cancer	_____	Blindness	_____
Glaucoma	_____	Stroke	_____
Asthma	_____	High blood pressure	_____
Allergies	_____	Heart disease	_____
Macular degeneration	_____		